STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G058	A. BUILDING _____ B. WING _____	10/12/2007

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SYMBRAL	521 KENNEDY STREET, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS Surveyor: 17815 A recertification survey was conducted from October 10, 2007 thru October 12, 2007. The survey was initiated using the full survey process. A random sample of two clients was selected from a resident population of four men with various disabilities. A third client was added for a focused review of his behavior management plan and psychotropic medication regimen. The findings of the survey were based on observations, interviews with clients and staff in the home and at two day programs, interview with one client's medical guardian, as well as a review of client and administrative records, including incident reports.	W 000	Symbral will develop a policy to ensure that documents/records are placed within the individual files concerning habilitation, medical and life-changing issues. This policy will be reviewed on annual and PRN basis. QA will conduct semi-annual audits to ensure compliance. QMRP will monitor quarterly	11/30/07
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on observation, staff interview and record review, the facility's governing body provided general operating direction over the facility, except in the following areas: The findings include: 1. Cross-refer to W124. On October 12, 2007, at approximately 1:15 PM, interview with the Acting Qualified Mental Retardation Professional (AQMRP) indicated that Client #2's medical guardian was notified of the client's medical issues and team meetings. Further interviews and record review, however, revealed no	W 104	Cross reference to w124	11/30/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Yvonne Mohammed	CEO	11/12/07

ıy deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ıer safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ɔgram participation.

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W 104	Continued From page 1 evidence that the governing body had established and implemented policies and procedures to ensure that clients' court-appointed guardians were informed of the client's medical condition and attendant risks of treatment, and to properly document this review in the clients' records. 2. Cross-refer to W143. The governing body failed to establish and implement policies and procedures that specified how facility staff should document each contact and/or communication with guardians (and/or involved family members) in the clients' records. 3. Cross-refer to W148. The governing body failed to ensure that the facility implemented its policies and procedures regarding the notification of clients' court-appointed guardians of significant incidents and/or changes in the clients' condition. 4. Cross-refer to W136. The governing body failed to ensure client access to their personal funds for attending preferred recreational outings, such as dancing at nightclubs and attending live theatre productions, or otherwise ensured client opportunity to participate in social and community activities. 5. Cross-refer to W149.5. The governing body failed to establish and implement an effective monitoring system to ensure client safety during transportation. Client #1's wheelchair was not properly secured while traveling in the facility van in the community. While straps were available, staff indicated that they had not received training and therefore were unaware of how to use them properly. 6. Cross-refer to W159. The governing body	W 104	2. Cross refer to W143 and adopted. 3. Symbral will develop a protocol to ensure that individual have access to the funds for personal use. 4. Governing body will ensure that all staff involved in transporting individuals will be trained prior to providing service to the individual. House Manager and QMRP will provide reviews with staff. 5. Symbral will develop a transportation /safety review form to document staff training. Oneness Mobility Services will conduct staff training and train the trainer.	11/30/07 11/30/07 12/15/07 12/15/07

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W 104	Continued From page 2 failed to ensure continuity of QMRP reviews, supports and services to ensure accurate and consistent implementation of client programs and services throughout the previous 12-month period. 7. Cross-refer to W194. The governing body failed to ensure that staff received the training necessary to accurately and effectively implement and document clients' programs.	W 104	6.Governing body will ensure that Active Treatment Services are provided and updated for individuals served. QA will monitor quarterly.Cross refer to W159 and adopted. 7. Governing Body will ensure that the staff receive training on proper implementation and documentation of individual programs	12/15/07 11/30/07
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on interview and record verification, the facility failed to maintain a record keeping system that contained all pertinent client information in the active client files, for two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. On October 12, 2007, review of Client #1's medical chart revealed a May 2007 Monthly Nurse Note, dated May 31, 2007, that included the following: "5/28/07 emergency room visit for seizure activity." No additional information was included in the monthly note to describe the nature of the seizure. A Nursing Progress Note from May 28, 2007 indicated: "...seizure activity and lasted 5 minutes. Consumer was taken to <hospital name> ER via 911... discharged from <hospital name> in stable condition... was	W 111		

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W 111	Continued From page 3 discharged 4 AM..." Further review of the client's records during the survey failed to show evidence that staff who were with Client #1 at the time of his seizure had documented the signs and symptoms on a seizure report form, in accordance with agency policies. It should be noted that on October 16, 2007 (post-survey), the facility sent to the State agency a fax transmittal that included, among other items, a seizure report form. The form was dated 5/2 <sic> and described in greater detail the signs and symptoms of a seizure that Client #1 experienced. Further review of the form revealed a space designated "Signature of RN or MD" had been signed by the facility's designated LPN. The faxed materials did not indicate the source of the seizure report form (i.e. where it had been located). 2. Cross-refer to W124.4.c. On October 12, 2007, review of Client #2's record revealed that he had been seen by GI specialists several times, and undergone diagnostic procedures, since he had surgery on a hiatal hernia in June 2006. The most recent GI appointment documented was on August 21, 2007. It was later determined that additional tests had occurred but had not been documented appropriately in the client's record. On October 16, 2007, the facility sent to the State agency a fax transmittal that included, among other items, a diagnostic report dated September 20, 2007 that had not been in the client's record at the time of the survey. The report indicated that Client #2 underwent an upper GI series examination on September 20, 2007 in a hospital radiology clinic. Across the top of the diagnostic report was an 'electronic stamp' indicating that it	W 111	Staff will be inserviced on documentation of episodes of seizures activity. House Manager will ensure that report is completed prior to the staff and transferred to the nurse, unless the individual required emergency room intervention, medication nurse or charge nurse will complete progress notes as soon as possible, but not later than 24 hours and filed in the individuals medical records. Charge nurse will review on a monthly basis. Director of Nursing will review quarterly. QMRP and QA will monitor to ensure	11/30/07

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W 111	Continued From page 4 was sent to the facility earlier that same day (October 16, 2007), almost 1 month after the procedure was performed. It should be noted that there were 2 handwritten notations added to the bottom of the diagnostic report. Whoever made those entries (in the same handwriting) had neither signed nor dated the entries.	W 111	2. Director of Nursing will ensure that all diagnostic reports are followed up, reviewed , filed in the individuals book. Director of Nursing will ensure that reviewers (Nurses, Doctors) sign and date document. Charge Nurse will review medical files quarterly to ensure that results of labs and diagnostic tests are properly filed and ready for reviews. DON and QA will monitor to ensure compliance. Cross references W124-4.c and adopted.	11/30/2007
W 112	483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on observation and staff interview, the facility failed to keep confidential all information contained in each client's record, for one of the four clients residing in the facility. (Client #2) The finding includes: On October 10, 2007, at 5:35 PM, a note was observed posted openly on a cabinet door in the kitchen. Review of the note revealed that it included the client's full name and a listing of foods that he was to avoid eating due to a medical condition. This practice failed to ensure the confidentiality of the clients' personal information. It should be noted that on October 12, 2007, at 7:51 AM, review of the facility's Policies and Procedures Manual revealed a policy regarding confidentiality of information (Section 5.a.) as follows: "Each program administrator shall protect	W 112	QMRP will ensure individuals' personal information is no longer posted in areas that violate their privacy and confidentially, staff will be inserviced on individual records and information protection of confidential. Any information that need to be seen which is confidential but must be in an accessible area, will have the individual initials instead of the full name. QMRP and QA will monitor to ensure compliance.	11/30/07

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W 112	Continued From page 5 the confidentiality of personally identifiable information at collection, storage, disclosure and destruction stages."	W 112		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on interview and record verification, the facility failed to ensure the right of each client's legal representative to be informed of the client's medical condition and proposed procedures, for one of the two clients in the sample. (Client #2) The findings include: During the October 11, 2007 entrance conference, at approximately 11:20 AM, the House Manager indicated that Client #2 had a court-appointed guardian. Moments later, he presented the client's Individual Support Plan, dated April 5, 2007, in which the guardian "for medical purposes only" was documented. On October 12, 2007, at 2:01 PM, review of the client's medical chart revealed a court document appointing the medical guardian, effective July 19, 2001. On October 12, 2007, at 9:21 AM, review of a report prepared by Client #2's medical guardian,	W 124	QMRP will create a schedule for ISP and semi-annual meeting and forward to legal guardian. QMRP will forward to legal guardian on a quarterly progress note and communicate on an as need basis on medical updates, treatment process and procedures. Records will be kept within the individuals file on the transfer of this report via Communication Transmission Log. Guardian will be requested to transmit brief notes confirming receipt of information. QMRP and QA will monitor to ensure compliance.	11/30/07

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W 124	Continued From page 6 dated July 19, 2006, revealed "a couple of hospitalizations for gastric problems" during the previous year. The guardian's most recent documented visit to the facility was June 25, 2006. The client's medical chart revealed that he had undergone surgery in June 2006 to repair a hiatal hernia, and had a history of GI bleeding, mild esophagitis, Barrett's esophagus syndrome and left sided colitis. Further review of the client's record revealed the following: 1. Client #2 had an ultrasound procedure of the abdomen performed on October 5, 2006. 2. He had undergone upper GI tests on October 24, 2006. This was 3 months after the last documented contact by the facility to the medical guardian. The corresponding report revealed that the findings had been "limited" due to the "patient could not follow commands and did not wish to drink the barium." [Note: They were, however, able to view some of his system and no new problems or diagnoses were indicated.] 3. Case conference was held on December 7, 2006 at which time some members of his interdisciplinary team met to review 3 reports prepared by an outside entity regarding his nutritional intake and the use of Boost nutrition supplement three times daily. Further review of the case conference documents failed to show evidence that the medical guardian (1) had been in attendance, (2) had been invited to participate, and/or (3) would be informed of the team's decisions following the case conference. 4. The former House Manager documented a June 14, 2007 visit to a GI clinic at which time the doctor refused to provide services and referred	W 124		

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W 124	Continued From page 7 Client #2 back to the doctor who had performed the hernia operation in June 2006. The House Manager's note did not indicate notification of the medical guardian and no other evidence of such notification was evidenced in the client's record. 5. At approximately 6:30 PM, further review of Client #2's medical chart revealed documented visits to GI consultants on June 26, 2007 (recommended "GI medicine to evaluate") and on August 21, 2007 (reflected "episodes of vomiting in June..." and recommended "patient should have head of bed elevated" and a "barium swallow study with upper GI series..." The client's record did not, however, reflect any communications with the medical guardian regarding these consultations and/or recommended treatments and diagnostic procedures. It should be noted that one of the GI specialists contacted by the facility since then had refused to serve the client because he no longer accepted DC Medicaid insurance. 6. On October 12, 2007, at approximately 1:15 PM, interview with the Acting Qualified Mental Retardation Professional (AQMRP) indicated that Client #2's medical guardian was notified of the client's medical issues and team meetings. Further interviews and record review, however, revealed no evidence that the facility had established a policy and procedure that specified how facility staff should document each contact and/or communication with guardians (and/or involved family members). 7. On October 16, 2007, the facility sent to the State agency a fax transmittal that included, among other items, a diagnostic report dated September 20, 2007 that had not been in the	W 124		

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W 124	Continued From page 8 client's record at the time of the survey. The report indicated that Client #2 underwent an upper GI series examination on September 20, 2007 in a hospital radiology clinic due to "nausea and vomiting." The report's conclusion included the following: "Moderate sized hiatal hernia with distal esophageal stricture. Would recommend upper endoscopy to correlate further." 8. A telephone interview with Client #2's medical guardian on October 15, 2007, at 2:20 PM, revealed that he had not been notified of the client's medical consultations or health status during the past 12 months.	W 124		
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on observation, the facility failed to implement an effective system to protect the clients' rights for privacy during medication administration, for three of the four clients residing in the facility. (Clients #1, #2 and #4) The findings include: The evening medication pass was observed on October 10, 2007, beginning at 5:50 PM. The medication nurse did not protect the clients' right to privacy during the administration of medications, as follows: 1. at 6:01PM, the medication nurse was	W 130	Director of Nursing will inserviced nurses on privacy in the administration of medications and treatments. Director of Nursing monitor the delivery of service over the next 90 day and will conduct random proficiency audit on this practice.	10/16/07 and ongoing

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W 130	Continued From page 9 observed administering medications to Client #4 at the dining room table while 1 of his peers sat next to him at the table. The client received Zyprexa and Lactulose; 2. at 6:13 PM, the nurse was observed administering medications to Client #1 in the dining room, while 2 of his peers sat at the table. The client received Depakote by mouth and Nasonex nasal spray to each nostril; and, 3. at 6:23 PM, the nurse was observed administering medications to Client #2 at the dining room table while 3 of his peers sat at the table. The client received Terazosin and Reglan by mouth and baby oil was applied to both ears.	W 130		
W 136	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on client and staff interviews and record verification, the facility failed to provide opportunities to participate in community outings of choice, to meet the needs of two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. The facility failed to ensure Client #1 was afforded the opportunity to attend live theatre (musicals and plays) in accordance with his assessed interest, as evidenced by the following:	W 136	QMRP will ensure that individual #2 and all other individuals supported will participate in recreational/community/social activities of choice. House Manager will ensure that funds are made available and individuals participated in such activities by requesting funds when necessary from the administration in a timely manner. The House Manger will provide a month calender of the activities planned and preferred and communicate any barriers which prevented individualized participation. QMRP will follow up with House Manager to resolve issues and ensure the individual participation in preferred recreational activities. QA will monitor quarterly to ensure compliance.	12/15/07

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W 136	Continued From page 10 a. On October 12, 2007, at approximately 4:10 PM, review of Client #1's Individual Support Plan (ISP), dated March 21, 2007, revealed the following statement on page 7: "Love going to the theatre enjoys musicals as well as plays." Review of his IPP revealed a service objective in his IPP for him to "participate in a minimum of 4 recreational activities per month." However, further review of the program revealed that it failed to outline potential recreational activities of choice. Review of the client's community outings/ recreational activities record revealed no evidence that he had been to a live theatre during the previous 12 months. b. At 5:04 PM, the client was interviewed in his bedroom. He confirmed that he enjoyed attending live theatre performances but had not had the opportunity to do so. c. At approximately 5:30 PM, interview with the recently-hired House Manager revealed that he was unaware of how community outings were selected. d. At 7:19 PM, interview with 2 direct support staff persons revealed that Client #1 enjoyed going to the Chateau nightclub on Thursday nights. His record did not, however, reflect outings to the Chateau in recent months. The staff acknowledged that the most recent outing to the Chateau was documented on March 29, 2007. Staff routinely selected activities and the four clients went together. They further indicated that since the March 29, 2007 outing to the Chateau, requests for accessing the client's personal funds to pay for admission to the nightclub (or other activities that cost money) had	W 136		

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W 136	Continued From page 11 not been acted upon by administrators at the corporate office. Review of the client's documented outings revealed that they consisted of outings to parks, supermarkets, shopping malls and/or driving past monuments and government buildings ("sightseeing"), all at no cost. Subsequent review of the client's financial records for the 9-month period December 31, 2006 - September 28, 2007 revealed that except for a 6-day vacation to Ocean City, MD at the end of July 2007, the client had not spent any personal funds for anything, community outings included. (Note: According to a bank statement dated September 28, 2007, his bank balance was more than $1,000.) 2. On October 12, 2007, review of Client #2's record of community outings revealed a listing of group outings that consisted of the same activities documented for Client #1, namely parks, supermarkets, shopping malls or driving past monuments and government buildings. His record did not reflect individualized outings of personal choice and no recent opportunities to attend social, religious or community group activities.	W 136	QMRP will ensure that individuals have the opportunity to participate in different events/ activities if they choose to. QMRP will monitor implementation for specific preferences (religious, cultural, social provided.) QA will monitor on a quarterly basis to ensure compliance.	12/15/07 and ongoing
W 143	483.420(c)(1) COMMUNICATION WITH CLIENTS, PARENTS & The facility must promote participation of parents (if the client is a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on interviews and record verification, the	W 143		

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W 143	Continued From page 12 facility failed to promote the participation of family members and/or legal guardians in the active treatment process, for two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. During the October 11, 2007 entrance conference, at approximately 11:20 AM, the House Manager indicated that Client #1's former foster mother remained involved in the active treatment planning and review process. On October 12, 2007, at approximately 1:20 PM, telephone interview with the Acting QMRP revealed that an "annual calendar" of Individual Support Plan (ISP) meeting dates was sent to family members and guardians. The facility reportedly sent reminder letters 90 days prior to the meeting and then telephoned them within 30 days of the meeting. Further interview, however, revealed that the facility had not established a formal means for documenting these contacts with family members and/or guardians in the clients' records. On October 12, 2007, at 4:05 PM, review of the client's Individual Support Plan (ISP), dated March 21, 2007, revealed no indication that the foster mother had attended the annual meeting. Further review of the client's record failed to show evidence that the foster mother had been invited to the March 21, 2007 or other interdisciplinary team meetings. At 5:05 PM, Client #1 stated that his most recent visit with his foster mother had been the previous Thanksgiving. Direct support staff present at the time confirmed that this had been his last visit. This surveyor was unable to verify in the record that the foster mother had received the ISP calendar, 90 day reminder letter or received telephone calls to promote her participation in the	W 143	Cross reference to W124 and adopted.	11/30/07

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W 143	Continued From page 13 planning and review process. 2. Cross-refer to W124. Client #2 had a court-appointed guardian assigned "for medical purposes only." The facility, however, failed to promote the guardian's participation in the interdisciplinary team process, as follows: a. On October 12, 2007, review of the client's record revealed there had been a case conference held on December 7, 2006 at which time some members of his interdisciplinary team met to review 3 reports prepared by an outside entity regarding his nutritional intake and the use of Boost nutrition supplement. Further review of Client #2's medical chart revealed documented visits to GI consultants on June 26, 2007 (recommended "GI medicine to evaluate") and on August 21, 2007 (reflected "episodes of vomiting in June..." and recommended "patient should have head of bed elevated" and a "barium swallow study with upper GI series..." The client's record did not, however, reflect any communications with the medical guardian regarding these consultations and/or recommended treatments and diagnostic procedures. b. On October 15, 2007, at 2:20 PM, the medical guardian was interviewed by telephone. The interview revealed that, among other things, he was previously unaware that a case conference was held on December 6, 2006 to discuss the client's nutrition needs. c. Interviews and record review revealed no evidence that the facility had established a policy and procedure that specified how facility staff should document each contact and/or	W 143	W143 1 a-c Cross reference W124 and adopted.	11/30/07

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W 143	Continued From page 14 communication with guardians (and/or involved family members).	W 143		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on interview and record verification, the facility failed to notify clients' legal guardians of significant changes in health condition and/or incidents involving injuries, for the one (out of two clients sampled) with a court-appointed guardian. (Client #2) The findings include: During the October 11, 2007 entrance conference, at approximately 11:20 AM, the House Manager indicated that Client #2 had a court-appointed guardian. Moments later, he presented the client's Individual Support Plan, dated April 5, 2007, in which the guardian "for medical purposes only" was documented. On October 12, 2007, at 2:01 PM, review of the client's medical chart revealed a court document that documented the appointment of the medical guardian, effective July 19, 2001. 1. On October 11, 2007, at 8:21 AM, review of incident reports revealed that Client #2 was taken to an emergency room on May 31, 2007, after he sustained an injury to his forehead. Further	W 148	Cross refer to W124 and adopted. Any unusual incident that involves major medical or emergency room visits will be communicated to the medical guardian and/ or family representative. Communication tracking log will be completed and confirmation documentation will be placed within the individuals files. (confirmation note from the recipients, faxes, certified mail, signature receipt form)	11/30/07

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W 148	Continued From page 15 review of the incident report failed to show evidence that the medical guardian had been informed. 2. On October 12, 2007, at approximately 1:15 PM, interview with the Acting Qualified Mental Retardation Professional indicated that the facility's policies stated that notification of clients' families and guardians would follow major incidents, such as emergency room visits, and this would be documented on the incident report. Notification of such incidents should be documented on the incident report. She stated that she would seek written evidence that the guardian was contacted about the May 31, 2007 emergency room visit. No written evidence that the guardian was informed of the aforementioned incident was presented before the end of the survey later that evening. 3. On October 15, 2007, at 2:20 PM, Client #2's medical guardian was interviewed by telephone. The guardian indicated that he had not been notified of any unusual incidents during the past 12 months. 4. Cross-refer to W124. The October 15, 2007 telephone interview also revealed that the medical guardian had not been informed of changes in the client's medical condition and/or medical consultations during the past 12 months. The Client #2's record, however, reflected (a) an ultrasound procedure of the abdomen was performed on October 5, 2006; (b) upper GI tests were performed on October 24, 2006; (c) incidents of vomiting in June 2007; (d) an August 21, 2007 evaluation by a GI specialist; and (e) an upper GI series examination was performed on September 20, 2007 in a hospital radiology clinic	W 148		

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W 148	Continued From page 16 (results indicated another hiatal hernia was evidenced). This is a repeat deficiency. See Federal Deficiency Report dated December 29, 2006.	W 148		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on interviews and record verification, the facility failed to establish and/or implement policies that ensured the health and safety of its clients, for two of the four clients residing in the facility. (Clients #1 and #2) The findings include: 1. Although both the Acting QMRP and the Incident Management Coordinator stated on October 11, 2007, (at 3:49 PM and 4:18 PM, respectively) that all incidents, including injuries of unknown origin, were reported immediately to their administrator, review of incident-related documentation earlier that day and then just moments before this discussion failed to show evidence that their administrator was being notified. Review of the agency's Incident Management policies earlier, at 3:21 PM, revealed that they did not specify how facility staff should document said notification. Further interview with the Acting QMRP and the Incident Management Coordinator confirmed that there was no established policy proscribing how the	W 149	W149 1. and 2.a. and b. Symbral's Incident Report Form has been revised to include, documentation of notification of the CEO. The CEO and Incident Management Coordinator will be provided a copy of the incident report within 24 hours or next business day for review. The house Manager and QMRP have been notified of forwarding a copy of the incident report and investigation within five (5) business days. QMRP will verbal inform State agency and CEO and ensure same is documented on incident report. QA and Incident Management Coordinator will monitor quarterly to ensure compliance.	11/30/07

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W 149	Continued From page 17 notification of their administrator should be documented. 2. Although the Acting QMRP and Incident Management Coordinator stated that all emergency room visits and/or incidents that present a significant risk to the clients' safety or welfare were to be reported to the State agency, in accordance with District law (22 DCMR, Chapter 35, Section 3519.10), review of incident reports and corresponding documentation failed to show evidence that the following incidents were reported to the State agency: a. on May 31, 2007, Client #2 was taken to a hospital emergency room after sustaining a laceration to his forehead. b. on February 22, 2007, Client #1 was transported from his day program to a hospital emergency room via ambulance after experiencing lethargy. 3. Cross-refer to W153. The facility failed to consistently report significant incidents, including injuries of unknown origin, to the State agency and on a timely basis. For example, Client #1's emergency room visit on February 22, 2007 due to lethargy, and Client #2's emergency room visit on May 31, 2007 after sustaining a laceration to his forehead were not reported. 4. Cross-refer to W154. The facility failed to promptly investigate Client #2's injury, after staff presented contradictory information, to determine whether its policies prohibiting abuse and neglect had been implemented. 5. Cross-refer to W156. The facility failed to	W 149	W149.3 QMRP will ensure that significant incidents and injuries of unknown origin are reported to the State Agency, The Administration and Incident Coordination immediately or within twenty-four (24) hours . QMRP will forward information on State notification to the Administration and Incident Coordinator. Incident Coordinator and QA will monitor quarterly to ensure compliance. W149.4 Cross refer to W154. and adopted	11/30/07 11/30/07

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W 149	Continued From page 18 consistently report the results of all incident investigations within 5 working days. For example, Client #2's May 31, 2007 incident investigation report was dated June 21, 2007 and there was no documented evidence that the administrator had been notified of the results prior to issuance of the report. 6. The facility failed to establish and implement an effective monitoring system to ensure client safety during transportation, as evidenced by the following: a. On October 11, 2007, at approximately 8:04 AM, clients and staff were loading into a passenger van that was parked outside the facility. The driver used a wheelchair lift to assist Client #1 into the back area of the van. He did not secure the wheelchair with any straps or mechanism before closing the back door. The driver then got in the driver's seat and the House Manager sat in the front passenger seat. A moment later, they started to pull away without having secured the client's wheelchair. b. At approximately 8:06 AM, this surveyor asked the driver to stop the vehicle. After opening the back door to the van, the driver looked at Client #1's wheelchair and stated that it was adequately secured because the wheelchair lift had been closed all the way. Indeed, the back of the wheelchair was up close to the lift mechanism, which might reduce the amount of front/back motion. However, there was significant open space (at least 2 feet) to either side of the wheelchair, thereby leaving it subject to tipping over. c. When asked about the chains and straps	W 149	W149.5 Cross refer to W156 and adopted W149.6a,b,c,d,e Staff were inserviced on "fastening seat belt while in wheelchair" and "ensuring wheel chair locked down while in the van" on 10/13/2007. Staff have been instructed to use a 2 person system, whereby when 2 staff are present one will complete the task and the other will re-check to ensure the individual is secure and safe. Staff have been inserviced that if equipment is faulty do not use and report to House Manger immediately. House manager and QMRP will provide random audit over the next 90 days. QA will monitor quarterly to ensure compliance.	11/30/07 10/13/07 and ongoing

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W 149	Continued From page 19 observed on the floor of the van, underneath the back seat and next to where Client #1's wheelchair was placed, the driver picked up a strap, held it in various positions then indicated that he did not know how to secure the strap. He acknowledged that he had not received training on how to secure wheelchairs in the van, to ensure client safety. d. At approximately the same time, the House Manager joined in the conversation. He too indicated that he had not received training on how to properly secure wheelchairs, to ensure client safety. e. The next day (October 12, 2007), at 7:46 AM, Client #1 came into the living room and climbed into his wheelchair. The client used the wheelchair for travel to his day placement in the community. Client #3 quickly walked over to the Client #1 and fastened his peer's wheelchair seatbelt. The seatbelt, however, was not fully secured; it sagged loosely across his lap. The House Manager thanked Client #3 for having assisted his peer. Client #1 then wheeled himself out the front door to the van. It should be noted that Client #1's Health Management Care Plan, dated March 10, 2007 and updated September 4, 2007, reflected his "potential for falls." Staff were to receive training on the following: "Fasten seatbelt while in wheelchair" and "ensure wheelchair lockdown while in van." Oversight of these matters was assigned to the "nurse, staff and QMRP."	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of	W 153	W153 Cross refer to W149.3 and adopted	11/30/07

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W 153	Continued From page 20 mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on interview and review of incident reports, the facility failed to ensure that all incidents including injuries of unknown origin were reported immediately to the administrator and other officials in accordance with District law (22 DCMR, Chapter 35, Section 3519.10), for one of the four clients residing in the facility. (Client #2) The finding include: On October 11, 2007, beginning at 8:20 AM, review of incident reports revealed that on May 31, 2007, Client #2 was taken to a hospital emergency room after sustaining a laceration to his forehead. There was no evidence that this incident was reported to the State agency as required. In addition, although the Acting QMRP stated that all incidents were reported immediately to their administrator, there was no written documentation to verify that she had been notified timely of the incident. This is a repeat deficiency. See Federal Deficiency Report dated December 29, 2006.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.	W 154		

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W 154	Continued From page 21 This STANDARD is not met as evidenced by: Surveyor: 17815 Based on record review and interview, the facility failed to document that all injuries of unknown origin were thoroughly investigated. The finding includes: Incident reports and their corresponding investigation reports were reviewed on October 11, 2007, beginning at 8:20 AM. There were three incident reports written to describe an incident which had occurred on May 31, 2007. According to the incident reports, Client #2 sustained an injury to his forehead while in his bedroom along with a direct support staff person. There were written witness statements attached to the incident reports. Information included in some of the incident reports and statements differed substantively from the others. Of note, a second staff person who was on duty at the time of the incident wrote (twice) that the direct support staff person assisting the client had reportedly said he "didn't know" how the injury had occurred. The staff in question, however, later wrote that the client had tripped and hit his head on a dresser. Although on October 10, 2007, at 5:19 PM, the Acting QMRP had stated that all incident and investigation reports were kept together in one book at the main office and would be brought to the facility the next morning, there was no corresponding investigation report available for review that (next) day. Additional requests were made. At 4:07 PM, the Incident Management Coordinator (IMC) indicated that the former House Manager had left them before an interview	W 154	W154 Administration will receive copies of serious reportable incidents, emergency room visits and all reports of injuries of unknown origin in a documented format with 24 hours or next business day of the occurrence. The charge nurse/ DON will complete a preliminary summary of the ER visit or injury of unknown origin and forward it to the Administration and Incident Management Coordinator within 24 hours or next business day. QMRP will conduct an investigation unless there is a conflict of interest that prevents his or her involvement. The Incident Management Coordinator will monitor to ensure timely completion within 5 days. Copy of the report will be forwarded to the State Agency, DDS and the Administration will also received a copy of the report. QA will monitor Quarterly to ensure compliance.	11/30/07

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W 154	Continued From page 22 and therefore they "could not move forward... I would have to check and see whether a report" was ever generated. The IMC was unsure of the dates the direct support staff and House Manager had left but stated that he would check on the dates. He was certain that the one staff who repeatedly said that the other staff had answered he "didn't know" how the injury had occurred remained employed at the facility through the summer. When asked about the client's injury, the IMC said he didn't "recall him actually going to the ER on that incident." The IMC acknowledged that the incident had warranted further investigation, to determine whether agency policies to prevent abuse and neglect had been correctly implemented, just prior to the client's injury. At approximately 5:30 PM the next day (October 12, 2007), an investigation report was brought to the facility. The investigation report was dated June 21, 2007 (3 weeks after the incident). The report acknowledged some discrepancies in the initial statements then included the following: "Additional information from <direct support staff> and <former House Manager> is not available as both individuals has (sic) quit their positions... Based on the information available, the injury is considered to be an accident." Follow-up interview with the IMC revealed no evidence that the investigation had been initiated promptly. Review of staff in-service training records on October 12, 2007 revealed no evidence that staff, including administrative staff responsible for conducting investigations, had received additional training on incident management policies and	W 154		

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W 154	Continued From page 23 procedures, including investigation requirements, since the May 31, 2007 incident. The most recent documented training was held on January 31, 2007. This is a repeat deficiency. See Federal Deficiency Report dated December 29, 2006	W 154		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on record review and interview, the facility failed to document that the results of all investigations were reported to the facility's administrator within 5 working days, in accordance with facility policies and federal regulation. The finding includes: Cross-refer to W154. There were three incident reports written to describe an incident which had occurred on May 31, 2007. According to the incident reports, Client #2 sustained an injury to his forehead while he was in his bedroom with a direct support staff person. Information included in some of the incident reports and statements differed substantively from the others. On October 12, 2007, review of the corresponding investigation report revealed that it was dated June 21, 2007 (3 weeks after the	W 156	W156 Cross refer to W154 and adopted. Administration will ensure that the results of investigation are received within 5 working days of incident. Inservice training is scheduled for 11/15/2007 . Staff will receive annual updates and PRN refreshers. QA will monitor to ensure compliance.	11/15/07 and ongoing

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W 156	Continued From page 24 incident). The report acknowledged some discrepancies in the initial statements then included the following: "Additional information from <direct support staff> and <former House Manager> is not available as both individuals has (sic) quit their positions... Based on the information available, the injury is considered to be an accident." Follow-up interview with the Incident Management Coordinator revealed no evidence that the investigation had been initiated promptly. He also acknowledged that the incident had warranted further investigation, to determine whether agency policies to prevent abuse and neglect had been correctly implemented, just prior to the client's injury. There was no evidence that the results of this investigation were reported to the facility's administrator within 5 working days, and no evidence that the State agency was notified of the incident or the investigative findings. Note: Review of staff in-service training records on October 12, 2007 revealed no evidence that staff, including administrative staff responsible for conducting investigations, had received additional training on incident management policies and procedures, including investigation requirements, since the May 31, 2007 incident. The most recent documented training was held on January 31, 2007.	W 156		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.	W 159		

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W 159	Continued From page 25 This STANDARD is not met as evidenced by: Surveyor: 17815 Based on observation, interview and record review, the facility's Qualified Mental Retardation Professionals (QMRPs) failed to adequately monitor, integrate and coordinate clients' active treatment programs and services, for two of the two clients in the sample. (Clients #1 and #2). The findings include: During an October 10, 2007 telephone interview, at approximately 5:15 PM, the Acting QMRP stated that a previous QMRP had left the facility in July 2007. Since then, another QMRP had been hired but left after 2 weeks. Yet another QMRP was hired but he left within approximately 24 hours. Throughout this period, she and the facility's Incident Management Coordinator reportedly shared in covering QMRP duties. Gaps in QMRP services, however, were identified, as follows: 1. Cross-refer to W124. The QMRP failed to ensure that Client #2's court-appointed medical guardian was informed of the client's medical condition and proposed procedures. 2. Cross-refer to W130. The QMRP failed to ensure that clients received their medications in a setting that assures confidentiality of personal medical information. 3. Cross-refer to W136 and W247. The QMRP failed to ensure that clients experienced community-based social and recreational outings that were in acccordance with their assessed interests and preferences.	W 159	W159.1 - 159.10 A Full-time QMRP was hired on 10/16/2007. QMRP has initiated reviewing of all Active Treatment Goals in conjunction with medical service delivery. QMRP has identified areas of program implementation, documentation and programmatic plans for revision. Initial notes are being placed in the individuals records correcting identified state deficiencies as well as QMRP revisions. Data sheets are being revised and updated and staff inservice training will follow revisions. DON and QMRP will review program implementation to ensure compliance. QMRP will ensure that recommendations provided by consultants/ clinicians which are adapted by the ISP are implemented after the staff has been trained. QMRP/ QA will monitor to ensure compliance. Cross refer to W124, W130, W136, W247, W143, W148, W436, W159.7, W193.3, W460, W255 and adopted.	12/15/07

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W 159	Continued From page 26 4. Cross-refer to W143. The QMRP failed to establish and implement an effective system for promoting the participation of family members and/or legal guardians in the active treatment process, and documenting contacts with all concerned parties in the clients' records. 5. Cross-refer to W148. The QMRP failed to establish and implement an effective system for informing clients' involved family members and/or legal guardians of significant incidents. 6. Cross-refer to W436. The QMRP failed to ensure that clients were provided with and taught to use their adaptive equipment, such as coated spoons, protective elbow and knee pads, wrist and/or elbow splints and shoulder exercise pulleys, and to ensure that staff received corresponding training. 7. The QMRP failed to follow-up on a recommended range of motion exercise program for Client #1, as follows: Client #1's physical therapy assessment, dated February 27, 2007, included a recommendation that he engage in an exercise program "to improve range of motion in his hands... will tolerate range of motion exercises to his hands 10 of 10 trials, days per week for 12 consecutive months." There was no corresponding program in the client's IPP book. On October 12, 2007, at 7:28 PM, interview with staff (coupled with further review of the client's IPP) revealed that staff had not implemented range of motion exercises of his hands. They stated that they feared he would be injured; "we can't... has contractures... the bones have locked." Staff interview also revealed that they had not implemented Client #2's	W 159		

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W 159	Continued From page 27 recommended shoulder exercise using a pulley. A pulley had been delivered in February 2007; however, staff said thay had not been trainined and there was no corresponding data collection sheet in the client's program book. Interview with Acting QMRP and review of staff in-service training records revealed no documented evidence that staff had received training from the physical therapist or the QMRP during the previous 12 months. 8. Cross-refer to W194.3. The QMRP failed to ensure that staff had the necessary information and training to ensure proper implementation and documentation of Client #1's communication training program. There was no evidence that the QMRP had met with staff to decide upon the 10 wh and/or how questions they were to ask the client when implementing the program. Staff were not writing down the wh and/or how questions they asked, in accordance with the program as written by the speech/ languag therapist. Staff had used a + sign to document that they asked the client a question but did not document the client's response, as indicated in the program. The House Manager and staff indicated that they had not received training from either the speech/ language therapist or the QMRP on how to implement the clients' communication programs. In-service training records showed no evidence that staff had received training on how to implement the clients' communication programs. 9. Cross-refer to W460. The QMRP failed to ensure clients' nutritional intake was in accordance with prescribed dietary orders. 10. Cross-refer to W255. Review of Client #1's	W 159		

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W 159	Continued From page 28 and #2's records failed to show evidence that their programs had been reviewed periodically by a QMRP since they were established following their annual ISP meetings held March 21, 2007 and March 6, 2007, respectively (7 months prior to the survey).	W 159		
W 194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on observations, staff interviews and review of staff in-service training records, the facility staff failed to demonstrate competency in the implementation of each client's individual program plan, for two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. The facility failed to ensure staff displayed competency in utilizing Client #1's adaptive equipment. a. Cross-refer to W436.1. During observations at dinner on October 10, 2007 and at breakfast the following morning, Client #1 ate with a small (child-sized) metal spoon with a blue and green plastic handle. Review of the client's record on October 12, 2007 revealed that he was prescribed a plastic-coated spoon for use at all meals. Upon inquiry at 7:18 PM, staff presented a coated spoon (pink) which had not been used by the client during the survey. Review of staff	W 194	W194.1.a. Staff have been inserviced on individual #1 Adaptive equipment (coated spoon) on 10/24/2007. QMRP will ensure that all staff are inserviced on individuals' adaptive equipment. House Manger and QMRP will monitor to ensure proper program implementation. House Manager and QMRP will conduct random proficiency audits over the next 90 days and ongoing there after. QA will monitor quarterly. Cross refer to W436.1 and adopted.	10/24/07 and ongoing

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W 194	Continued From page 29 in-service training records revealed no evidence that the staff observed working with the client on October 10 and 11, 2007 had received training on the use of his coated teaspoon. In addition, the recently-hired House Manager indicated on October 11, 2007, at 10:52 AM that he was previously unaware of the client's need for an adaptive spoon. b. Cross-refer to W436.2. Client #1 was observed in the home on the evening of October 10, 2007 and again the next morning, followed by day program observations and then additional observations that afternoon (October 11, 2007) in the home. At no time was the client observed using elbow of knee pads while he moved about 'on all fours.' However, on October 12, 2007, review of Client #1's ISP, dated March 21, 2007, revealed: "elbow and knee guards were prescribed to prevent injury to these areas of his body as he uses his elbows and knees to mobilize when indoors <client's name> prefers self-ambulation when indoors." At 5:10 PM, the client said he required staff assistance with putting them on. At 7:08 PM, two direct support staff were asked about the pads. They incorrectly stated that the pads should be worn when he was out in the community. Further interview revealed that staff were unaware that he should wear them while in the home. Review of staff in-service training records revealed no evidence that the staff observed working with the client on October 10 and 11, 2007 had received training on the use of his protective elbow and knee pads. c. Cross-refer to W436.3. Staff interview and review of in-service training records revealed that staff had not received training on the use of an "Elbow Comfy Splint" that remained in it's	W 194	W194.1.b, c, and d. QMRP and House Manger will implement staff inservice training provided by PT. QMRP will monitor to ensure proper implementation and documentation. Cross refer to W436.2, W436.3, W159.7 and adopted.	12/15/07

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W 194	Continued From page 30 shipping carton. Staff also confirmed that the item had been received in late May 2007, as per the date marked on the shipping label. d. Cross-refer to W159.7. On October 12, 2007, interviews with direct support staff and the Acting QMRP as well as a review of staff in-service training records revealed no documented evidence that staff had received training from the physical therapist (PT) during the previous 12 months. It should be noted that there was no evidence that the PT had been reviewing clients' programs, or was otherwise involved in the active treatment process since the client's ISP meeting held on March 21, 2007. 2. Cross-refer to W436.4. The facility failed to ensure staff displayed competency in implementing Client #2's shoulder exercise program using a pulley. On October 12, 2007, review of Client #2's annual PT assessment, dated February 27, 2007, revealed that the physical therapist had recommended a shoulder exercise program involving the use of a pulley. Observations and staff interviews had not previously indicated the use of a pulley for the client's exercise program. At 7:35 PM, two direct support staff and the recently-hired House Manager presented a shipping box that contained Client #2's shoulder exercise pulley. Further interviews and review revealed that (a) the pulley had been delivered in February 2007, (b) to date, the client had not used the pulley, (c) staff had not been trained on the proper use, and (d) "someone" (staff not sure who) had not showed up at a previous staff meeting for in-service training (date not specified) and no additional in-service training had been provided to date.	W 194	W194.2 QMRP and House Manger will implement staff inservice training provided by PT. QMRP will monitor to ensure proper implementation and documentation.	12/15/07

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W 194	Continued From page 31 3. The facility failed to ensure that staff had the necessary information and training to ensure proper implementation and documentation of Client #1's communication training program, as follows: Client #1's IPP included a program whereby staff were to ask the client wh and/or how questions. The QMRP and staff were to decide on 10 wh and/or how questions they felt were appropriate, for asking throughout the client's daily routines (the speech/ language therapist had suggested during bathing, meals and leisure times). The 10 questions were to be written onto the program instruction sheet. The program further indicated that direct support staff were to select 1 question from the list of 10, write the question on the data collection sheet and then use the same question for at least 30 days. a. The space on the program instruction sheet that was designated for writing the 10 questions had been left blank. b. Review of the data sheets from August and September 2007 revealed that staff had not written down the wh or how question(s) asked. c. Review of the data sheets from August and September 2007 also showed inconsistent data collection. Documentation on the August sheet consisted of all I's during the entire month. According to the legend on the data collection sheet, an I represented "one word response." The September sheet, however, had all +'s. The legend said that + represented "verbal prompt." d. On October 12, 2007, the newly-hired House Manager could not explain the difference, and	W 194	W194.3 a - g QMRP and House Manger will proper implement and documentation of the program developed by the Speech Therapist. The staff will receive inservice training from the QMRP. Speech Therapist will review individual's progress. QMRP will monitor to ensure proper implementation and documentation.	12/15/07

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W 194	Continued From page 32 indicated that he was unfamiliar with the program. e. Two direct support staff who worked the evening shift with Client #1 were interviewed upon their return to the facility (from grocery shopping). The August and September 2007 data sheets showed their initials as having implemented the program on certain days. At 7:13 PM, they both confirmed that they routinely asked the client wh and/or how questions. However, they both stated that they marked a + to reflect that they had asked the client a question. They acknowledged that the + sign did not represent the client's response to the program. (Note: They also stated the client answers questions when asked, and did not need a verbal prompt to give an answer.) f. Further interview revealed that the direct support staff did not know that they should write down the question(s) that they asked him or that they should ask the same question(s) for 30 days. g. Staff interview and review of in-service training records failed to show evidence that the QMRP and/or the speech/ language therapist had trained them in how to implement the program and properly document the client's response.	W 194		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on observation, staff interview, and record review, the facility failed to ensure that each client was provided opportunities for choice,	W 247		

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W 247	Continued From page 33 encouraged and taught skills for self-management, for two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. Cross-refer to W136. The facility failed to ensure Client #1 was afforded the opportunity to attend live theatre (musicals and plays), which was an assessed preferred recreational/ social interest, as per his March 21, 2007 ISP. Review of his IPP revealed a service objective in his IPP for him to "participate in a minimum of 4 recreational activities per month." However, further review of the program revealed that it failed to outline potential recreational activities of choice. Review of the client's community/ recreational activities record revealed no evidence that he had been to a live theatre during the previous 12 months. Similarly, review of Client #2's documented recreational outings revealed no evidence that he was participating in social or community activities of his choice or assessed interests. 2. On October 10, 2007, the evening medication administration was observed, beginning at 5:50 PM. At 6:12 PM, the medication nurse placed Client #1's medication (Depakote, 500 mg tablet) in apple sauce and presented it to him. The nurse held the spoon and the medication cup in her hands, she spooned the medication into his mouth and then asked him to swallow and say ahhh. The client, who had been holding a cup of water in his right hand independently, then drank from the cup without any prompting. On October 12, 2007, at approximately 2:30 PM, review of the client's self-medication assessment, dated March 10, 2007, revealed the following: he "will be	W 247	W247.1 Cross refer to W136 and adopted W247.2 Nurse has been inservice on Individual #1 Medication Administration Assessment and the required protocol for implementation to ensure the individual's participation in self medication activities. Direct Care Staff, House manager and QMRP will monitor to ensure compliance. Charge Nurse /DON will conduct random audits over the next 90 day to ensure compliance and ongoing there after.	11/30/07

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W 247	Continued From page 34 encouraged to particpate with medication... will take medication cup from nurse... will swallow medications with fluid with verbal prompts..." The written self-medication procedures as outlined did not reflect the client's current medication administration process (with apple sauce) or skills. Although the client was observed using a spoon to eat food independently during meals, the medication nurse did not encourage him to use the spoon with the apple sauce, for self-management.	W 247		
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on observations, staff interviews and record review, the Acting Qualified Mental Retardation Professional (QMRP) failed to review and revise the Individual Program Plan (IPP) once the client successfully completed an objective identified in the IPP, for two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. The facility's Acting QMRP failed to revise Client #1's program objectives. Data collection sheets indicated that Client #1 had been "independent" in responding to his program to "learn to tell time correctly" since June 20, 2007.	W 255	W255 1. and 2. Cross refer to W159 and adopted. A Full-time QMRP was hired on 10/16/2007. QMRP has initiated review of all Active Treatment Goals in conjunction with medical service delivery. QMRP has identified area of program implementation, documentation and programmatic plans which are being revised. Initial notes are being placed in the individuals records outlining the corrective action and correcting the identified state deficiencies. QMRP will complete revisions on an as needed basis, and complete quarterly report. QA will monitor to ensure compliance.	12/15/07

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W 255	Continued From page 35 There were no revisions made to the program since he achieved at the stated criterion level. Interviews with the direct support staff and the Acting QMRP, and review of the client's record failed to show evidence that this or other program goals and objectives had been periodically reviewed by a QMRP. 2. Client #2's IPP indicated that the client would receive hand over hand support while brushing his teeth. Data collection sheets since April 2007 showed that he was performing at 100% with hand over hand assistance. The program had not, however, been revised to move the client to the next level towards independence. Interviews with the direct support staff and the Acting QMRP, and review of the client's record failed to show evidence that this or other program goals and objectives had been periodically reviewed by a QMRP.	W 255		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on interview and record review, the facility failed to provide nursing services in accordance with the client's needs, for two of the two clients in the sample. (Clients #1 and #2) The finding includes: 1. On October 12, 2007, review of Client #2's medical records revealed an annual Nursing Assessment dated March 1, 2007. The annual assessment documented 3 hospital emergency	W 331	W331.1, 2 and 4 DON has inserviced medication nurse on the "effective administration of medication" on 10/16/2007 and conducted an observation. The Charge Nurse and the DON will conduct random observation to ensure effective medication delivery Cross refer to W369 and adopted. A schedule of Nursing Quarterly reviews have been developed. The Consultant RN, the charge nurse and RN have reviewed the schedule for effective implementation. The consultant RN will forward to the DON notice of completion of the quarterlies. The DON will conduct scheduled follow-up to ensure that the documentation is within the individuals records.	11/30/07 and ongoing

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W 331	Continued From page 36 room visits during the previous 12 months, including surgery to repair a hiatal hernia. The RN then documented a quarterly review on June 30, 2007, and had updated the Health Management Care Plan (HMCP) accordingly. However, Client #2's record failed to show evidence that the RN had conducted a physical examination and review of the client's overall health condition since the June 2007 quarterly. [Note: There was documentation showing that the RN had reviewed his gastro-intestinal issues (only) on September 29, 2007. However, see paragraphs 2 and 3 below.] Subsequent interview with the Acting QMRP/ Director of Nursing revealed that she was under the impression that the RN had conducted a comprehensive quarterly review. 2. Staff interviews on October 10 and 11, 2007, at 6:53 PM and 10:52 AM, respectively, observation of Client #2's bed and bedroom on October 12, 2007, and review of his chart on October 12, 2007, beginning at approximately 9:25 AM, revealed no evidence that facility nurses ensured that the head of Client #2's bed was kept elevated, in accordance with the gastro-intestinal specialist's August 21, 2007 recommendation. Client #2's HMCP had been reviewed and updated by the consulting RN on September 29, 2007. However, review of the HMCP revealed that it did not reflect the gastro-intestinal specialist's August 21, 2007 recommendation to keep the head of Client #2's bed elevated. 4. Cross-refer to W369. Observation of the medication pass on October 10, 2007 revealed that the medication nurse did not implement effective means to administer Client #1's Nasonex spray and Client #2's baby oil drops in	W 331		

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W 331	Continued From page 37 both ears. Interview with the medication nurse revealed that she had not been observed by supervisors administering these medications. The LPN Coordinator for the facility was away on leave during the survey. Interview with the Acting QMRP/ Director of Nursing revealed that she had not observed a medication pass during the previous 12 months. Review of the in-service training records revealed no evidence that nursing staff had received training on the effective administration of nasal sprays, ear drops or other prescribed medications.	W 331		
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on interview and record review, the facility failed to ensure that clients received dental services in a timely manner, for one of the two clients in the sample. (Client #1) The finding includes: On October 12, 2007, at 4:13 PM, review of Client #1's dental record revealed that he received a dental assessment on October 4, 2006. On October 4, 2006, the dentist documented "heavy calculus deposits" and recommended "patient needs scaling... will submit pre-authorization to Medicaid..." The client's record documented a return visit to the dentist on June 6, 2007, at	W 356	Return Appointment to the dentist will be completed by 12/15/2007. In future any dental that is delayed more that 30 day because of pre-authorization, the DON, the Administration and DDS Case-manger will be notice and a record placed in individual. Nursing will continue to document efforts at least monthly until barrier is resolved or alternative intervention i.e. another vendor. DON will monitor to ensure compliance.	12/15/07

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W 356	Continued From page 38 which time the dentist found "moderate calculus deposits" and recommended "patient needs scaling... will submit pre-authorization to Medicaid..." Further review of the client's record that day revealed no evidence that the client received the recommended scaling, one year after it was first prescribed. Interview with the House Manager revealed that to date, the client had not had the scaling performed and there was no return appointment scheduled.	W 356		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on observation, interview and record review, the facility failed to ensure that medications were administered as prescribed, for two of the four clients residing in the facility. (Clients #1 and #2) The findings include: The evening medication administration pass was observed on October 10, 2007, beginning at 5:50 PM. The following errors were observed: 1. At 6:15 PM, the medication nurse squeezed 2 sprays of Nasonex Nasal spray into Client #1's left and right nostrils. The client, however, did not take in a breath at the appropriate moments when the nurse squeezed the nasal spray bottle. The nurse did not offer the client any instructions during this process. The nurse was not observed using effective means to ensure that Client #1	W 369	W369 Cross refer to W331.1 and adopted.	11/30/07

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W 369	Continued From page 39 received his prescribed nasal spray in accordance with the physician's orders. 2. At 6:25 PM, the medication nurse applied 5 drops of baby oil into Client #2's right ear. The client's head, however, was only slightly tilted towards the left. As soon as the oil entered his ear, he turned his head and the oil drained out of his ear (and down his neck) before the nurse put a ball of cotton in the ear. She repeated the same procedure in the left ear and again, the client turned his head quickly and the oil drained from his ear before she was able to place the cotton in his ear. The nurse did not offer the client any instructions during this process. The nurse was not observed using effective means to ensure that Client #2 received his prescribed baby oil in accordance with the physician's orders.	W 369		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on observation, staff interview and record review, the facility failed to ensure that clients were provided with and taught to use their adaptive equipment, such as coated spoons, protective elbow and knee pads, wrist and/or elbow splints and shoulder exercise pulleys, for two of the two clients in the sample. (Clients #1 and #2)	W 436		

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W 436	Continued From page 40 The findings include: 1. Facility staff did not ensure that Client #1's coated spoon was made available for use at all meals, as follows: On October 10, 2007, at 6:28 PM, Client #1 was observed eating with a small (child-sized) metal spoon with a blue and green plastic handle. The client was observed using the same little spoon at breakfast the next morning. On October 11, 2007, at 10:52 AM, the recently-hired House Manager stated that he did not know why the client used the little metal spoon. He then began to look through the client's record book. On October 12, 2007, at 4:05 PM, review of Client #1's Individual Support Plan (ISP), dated March 21, 2007, revealed that he was prescribed a coated spoon. At 7:18 PM PM, a direct support staff was asked asked about the coated spoon. She presented a teaspoon with a pink coating and stated that this was the spoon she always presented to the client. The pink-coated spoon had not been observed previously during the survey. 2. Facility staff did not encourage Client #1 to use elbow and knee guards that were prescribed to prevent injuries, as follows: On October 10, 2007, at 6:09 PM, Client #1 was observed navigating from his bedroom to the dining room. Despite his significant physical abnormalities, he was independent in moving about the home. He propelled himself with his hands on the floor, his legs were pointed backwards, and his left knee dragged across the floor. The client used the same means of moving	W 436	W436.1,2,3, and 4. PT conducted training on 10/24/2007. QMRP will monitor to ensure that individual and staff are inserviced on the use on adaptive equipment within a timely manner when the equipment is delivered. Should there be any delay/problems in source, securing and training of individual. QMRP will document efforts to resolve issue/s and update the administration on at least monthly and PRN. Consultant Clinician will be notified of the delay of the program implementation. QA will receive a copy of the IPP after the ISP is developed and will review in the home by the 30th day to ensure IPP goals have been commenced without delay.	12/15/07 and ongoing

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W 436	Continued From page 41 himself when he returned to his bedroom after dinner that evening and at other times he was observed moving about his home. By contrast, the client used a motorized wheelchair while out in the community, including his day program. On October 12, 2007, at 4:30 PM, review of Client #1's ISP, dated March 21, 2007, revealed: "elbow and knee guards were prescribed to prevent injury to these areas of his body as he uses his elbows and knees to mobilize when indoors <client's name> prefers self-ambulation when indoors." He had not been observed wearing protective elbow or knee pads previously during the survey. At 5:10 PM, the client was interviewed in his bedroom. His elbow and knee pads were stored openly near the bedroom door. He indicated that he required staff assistance with putting them on. When asked if he liked wearing them or not, he offered an unclear response. At 7:08 PM, two direct support staff were asked about the pads. They stated that the pads should be worn when he left for day program in the morning. He reportedly did not like wearing them and removed them promptly upon return home every afternoon. When asked if he should wear them while in the home, the staff replied that was not necessary since he was in bed most of the time and he did not use them when coming to the dining room for meals. 3. The facility failed to ensure that staff and clients were trained on the use of Client #1's prescribed wrist splints; therefore, the client had not used the wrist splints, as evidenced by the following: On October 12, 2007, at 5:35 PM, review of Client #1's latest annual PT assessment, dated	W 436		

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W 436	Continued From page 42 February 27, 2007, revealed the following recommendation: "<client's name> will benefit from rest (sic) splints." The client had not been observed using wrist splints during the survey. At 7:28 PM, two direct support staff were asked about the wrist splints. They went to the client's bedroom and retrieved his elbow and knee pads, saying that he did not like to wear them. At 7:35 PM, the same two staff and the recently-hired House Manager pointed to 2 shipping cartons that were on top of some shelves in the dining room. One of the boxes contained Client #1's "Elbow Comfy Splint." Further interviews and review revealed that (a) the shipping label indicated that the Elbow Comfy Splint had been delivered May 23, 2007, (b) to date, the client had not used the splint, (c) staff had not been trained on the proper use, (d) staff were unsure about the difference/ distinction between elbow splints and wrist splints, (e) a specialist had not showed up at a previously-scheduled staff in-service training (date not specified) and no additional in-service training had been provided. It should be noted that there was no evidence that the physical therapist had returned to the facility since the ISP meeting and/or reviewed the use of Client #1's adaptive equipment. 4. The facility failed to ensure that staff and clients were trained on the use of Client #2's shoulder exercise pulley; therefore, the client had not started the recommended exercise program in accordance with his ISP, as evidenced by the following: On October 12, 2007, at approximately 6:06 PM, review of Client #2's annual PT assessment, dated February 27, 2007, revealed that the	W 436		

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W 436	Continued From page 43 physical therapist had recommended a shoulder exercise program involving the use of a pulley. Observations and staff interviews had not previously indicated the use of a pulley for the client's exercise program. At 7:35 PM, two direct support staff and the recently-hired House Manager pointed to 2 shipping cartons that were on top of some shelves in the dining room. One of the boxes contained Client #2's shoulder exercise pulley. Further interviews and review revealed that (a) the shipping label indicated that the pulley had been delivered in February 2007, (b) to date, the client had not used the pulley, (c) staff had not been trained on the proper use, and (d) "someone" (staff not sure who) had not showed up at a previous staff meeting for in-service training (date not specified) and no additional in-service training had been provided. It should be noted that there was no evidence that the physical therapist had returned to the facility since the ISP meeting and/or reviewed the use of Client #2's exercise programs. It should be further noted that telephone interviews with the Acting QMRP on October 12, 2007, at 8:20 PM, and on October 15, 2007, at 11:31 PM, revealed the following: (1) she was unsure of the date the "specialist" had not appeared for the staff in-service training, (2) she thought the "specialist" may have been a representative from the company from which they had ordered the adaptive equipment, but could not confirm, (3) did not know whether the consulting physical therapist had been informed that the equipment had been delivered after/ since the February and March ISPs, and/or (4) whether the physical therapist had been contacted since the other "specialist's" in-service	W 436		

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W 436	Continued From page 44 training session had fallen through. There was no evidence that attempts had been made to reschedule the in-service training to meet Clients #1 and #2's needs.	W 436		
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on observation, interview and record review, the facility failed to ensure nutritional intake in accordance with prescribed dietary orders, for three of the four clients residing in the facility. (Clients #1, #2 and #4) The findings include: 1. Client #1 did not receive Instant Breakfast in accordance with physician's orders, as follows: a. The client was observed in the facility on October 10, 2007, beginning at 5:00 PM (when he was alone in his bedroom) until 6:58 PM (after he had finished dinner and retreated to his bedroom). Observations resumed the next morning, October 11, 2007. Client #1 was observed leaving his bedroom at 7:05 AM (he came to the dining room for breakfast) and remained within view until he and his peers left for their day programs, at approximately 8:09 AM. The client was not being offered Instant Breakfast during either of the observation periods. b. While direct support staff talked about Client	W 460	W460.1.a,b,c and d , W460.2.a and b. Staff have been inserviced on meal time protocol, individual diets and the menus on 10/26/2007. The House Manager and QMRP will monitor to ensure compliance. Staff will be inserviced annual, PRN and within his or her initial 30 days of employment. QMRP will monitor to ensure compliance.	10/26/07 and ongoing

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W 460	Continued From page 45 #2's Boost nutritional supplement, nothing was said about Client #1's orders for Instant Breakfast. Later that morning, the House Manager indicated during the Entrance Conference, at 10:23 AM, that Client #2's Boost was the only specialized nutritional/ dietary order prescribed. There was no mention of Client #1's order for Instant Breakfast on October 10 or 11, 2007. c. The order for Instant Breakfast, twice daily, was identified on October 12, 2007, during the record verification process. At 10:07 AM, review of Client #1's physician's orders, dated October 1, 2007, revealed that he was to receive a serving of Instant Breakfast twice daily, as a nutritional supplement. The House Manager was immediately interviewed. He said there was no Instant Breakfast in the facility at the time but that it was"on today's shopping list." d. The House Manager recalled having seen Client #1 receive the supplement since the time he (the House Manager) began working in the facility on October 2, 2007. However, further interview and record review revealed that the direct support staff had not been instructed to document the Instant Breakfast in the client's record. Without documentation, this surveyor could not confirm whether or not the client had received the supplement twice daily prior to the survey, in accordance with physician's orders. It should be noted that Client #1's weight chart documented that he had weighed 58 lbs. during the last half of 2006. After he went to the hospital in February 2007 for "persistent diarrhea," his weight dropped to 56 lbs. He held steady at 56 lbs. through May 2007; however, he weighed 55	W 460		

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W 460	Continued From page 46 lbs. in June 2007 and dropped to 54 lbs. in July 2007. A 4 lb. loss in weight represents a 6.9% drop in overall body weight. 2. According to Client #2's physician's orders, dated October 1, 2007, he was prescribed Boost nutritional supplement three times daily, to be served in between meals. Observations and interviews revealed that the Boost was not being offered between meals, as follows: a. Dinner was observed in the facility on October 10, 2007. The meal consisted of hamburgers, french fries, mixed vegetables and fruit cocktail for dessert. At approximately 6:29 PM, Client #2 began to stand up from his dining room chair, even though more than 50% of his meal remained on the plate. A direct support staff person asked him to "eat a little more." He responded with "I don't want." She repeated her request that he sit and eat, and he did. He ate two more bites of vegetables. He stopped eating at 6:32 PM, at which time another staff person presented him with a can of strawberry flavored Boost supplement. She poured the supplement into a glass and he finished it within approximately 90 seconds. The client left the table at 6:34 PM. b. Client #2 was observed at his day program on October 11, 2007, between 1:12 PM - 2:45 PM. The client began eating his lunch at 1:24 PM. At 1:36 PM, the day program Activities Coordinator indicated that the home sent a can of Boost supplement daily with the client. He further indicated that the client had experienced a period of significant weight loss previously; however, he thought he was "doing much better these days." The direct support staff who was assisting Client	W 460		

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W 460	Continued From page 47 #2 with his lunch added that she gave him the Boost after he finished his lunch. At approximately 2:37 PM, interview with the day program registered nurse revealed that the client's appetite fluctuated from day to day and that "he loves sweets." 3. As noted in the first paragraph above, it was determined on October 12, 2007 that Client #1 had not received his prescribed Instant Breakfast supplement during the survey period. At 10:09 AM, the House Manager indicated that Client #4 also was to receive Instant Breakfast, once daily. Client #4 was not observed receiving the supplement during the survey, neither the House Manager nor direct support staff had mentioned this supplement as part of the client's dietary regimen, there was no Instant Breakfast in the home on October 12, 2007 and the facility had not instituted a formal means for staff to document giving him the Instant Breakfast, in accordance with his physician's orders.	W 460	W460.3 Symbral has development a form to document the delivery of prescribed nutritional supplement to the individual. Staff have been inserviced and will report to the House Manager and QMRP if the supplied are not available. House Manager and QMRP will monitor to ensure compliance.	10/26/07 and ongoing.

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I 000	INITIAL COMMENTS Surveyor: 17815 A licensure survey was conducted from October 10, 2007 through October 12, 2007. A random sample of two residents was selected from a resident population of four men with various degrees of disabilities. A third resident was added for a focused review of his behavior management plan and psychotropic medication regimen. The findings of this survey were based on observations at the group home and two day programs, interviews with residents and staff and one resident's medical guardian, as well as the review of clinical and administrative records, including incident reports.	I 000		
I 002	3500.2 GENERAL PROVISIONS Each GHMRP licensee and residence director shall demonstrate that he or she understands that the provisions of D.C. Law 2-137, D.C. Code, Title 6, Chapter 19 govern the care and rights of mentally retarded persons in addition to this chapter. This Statute is not met as evidenced by: Surveyor: 17815 Based on observations, interviews and record review, the GHMRP licensee and residence director failed to demonstrate that he or she understood that the provisions of Title 7, Capter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) govern the care and rights of mentally retarded persons. The findings include: I. The facility failed to demonstrate protection of	I 002	I002.a Cross refer to W159 and W436.1 and adopted	12/15/07

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I 002	Continued From page 1 residents' rights to receive habilitation, care or both in accordance with their Individual Support Plans (ISPs) [Title 7, Chapter 13, § 7-1305.04(c), formerly § 6-1964(c)], as follows: A. During observations at dinner on October 10, 2007 and at breakfast the following morning, Resident #1 ate with a small (child-sized) metal spoon with a blue and green plastic handle. Review of the resident's record on October 12, 2007 revealed that he was prescribed a plastic-coated spoon for use at all meals. Upon inquiry at 7:18 PM, staff presented a coated spoon (pink) which had not been used by the resident during the survey. Review of staff in-service training records revealed no evidence that the staff observed working with the resident on October 10 and 11, 2007 had received training on the use of his coated teaspoon. Also see Federal Deficiency Report - Citations W159 and W436.1. B. Resident #1 was observed in the home on the evening of October 10, 2007 and again the next morning, followed by day program observations and then additional observations that afternoon (October 11, 2007) in the home. At no time was the resident observed using elbow of knee pads while he moved about 'on all fours.' However, on October 12, 2007, review of Resident #1's ISP, dated March 21, 2007, revealed: "elbow and knee guards were prescribed to prevent injury to these areas of his body as he uses his elbows and knees to mobilize when indoors <client's name> prefers self-ambulation when indoors." At 5:10 PM, the resident said he required staff assistance with putting them on. At 7:08 PM, two direct support staff were asked about the pads. They incorrectly stated that the pads should be worn	I 002	I002.b Cross refer to W159 and W436.2 and adopted	12/15/07

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I 002	Continued From page 2 when he was out in the community. Further interview revealed that staff were unaware that he should wear them while in the home. Review of staff in-service training records revealed no evidence that the staff observed working with the resident on October 10 and 11, 2007 had received training on the use of his protective elbow and knee pads.. Also see Federal Deficiency Report - Citations W159 and W436.2. C. Staff interview and review of in-service training records revealed that staff had not received training on the use of Resident #1's "Elbow Comfy Splint" that remained in it's shipping carton. Staff also confirmed that the item had been received in late May 2007, as per the date marked on the shipping label. Also see Federal Deficiency Report - Citations W159 and W436.3. D. The facility failed to ensure staff displayed competency in implementing Resident #2's shoulder exercise program using a pulley. On October 12, 2007, review of Resident #2's annual PT assessment, dated February 27, 2007, revealed that the physical therapist had recommended a shoulder exercise program involving the use of a pulley. Observations and staff interviews had not previously indicated the use of a pulley for the resident's exercise program. At 7:35 PM, two direct support staff and the recently-hired House Manager presented a shipping box that contained Resident #2's shoulder exercise pulley. Further interviews and review revealed that (a) the pulley had been delivered in February 2007, (b) to date, the resident had not used the pulley, (c) staff had not	I 002	I002.c Cross refer to W159 and W436.3 and adopted I002.d Cross refer to W159 and W436.3 and adopted	12/15/07 12/15/07

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	09G058	A. BUILDING _____ B. WING _____	10/12/2007

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I 002	Continued From page 3 been trained on the proper use, and (d) "someone" (staff not sure who) had not showed up at a previous staff meeting for in-service training (date not specified) and no additional in-service training had been provided to date. Also see Federal Deficiency Report - Citations W159 and W436.3. E. The facility failed to ensure that staff had the necessary information and training to ensure proper implementation and documentation of Resident #1's communication training program. There was no evidence that the QMRP had met with staff to decide upon the 10 wh and/or how questions they were to ask the resident when implementing the program. Staff were not writing down the wh and/or how questions they asked, in accordance with the program as written by the speech/ languag therapist. Staff had used a + sign to document that they asked the resident a question but did not document the resident's response, as indicated in the program. The House Manager and staff indicated that they had not received training from either the speech/ language therapist or the QMRP on how to implement the residents' communication programs. In-service training records showed no evidence that staff had received training on how to implement the residents' communication programs. Also see Federal Deficiency Report - Citation W159.8. F. The facility failed to ensure timely dental follow-up for Resident #1. On October 12, 2007, at 4:13 PM, review of Resident #1's dental record revealed that he received a dental assessment on October 4, 2006. On October 4, 2006, the	I 002	I002.e Cross refer to W159.8 and adopted	12/15/07

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I 002	Continued From page 4 dentist documented "heavy calculus deposits" and recommended "patient needs scaling... will submit pre-authorization to Medicaid..." The resident's record documented a return visit to the dentist on June 6, 2007, at which time the dentist found "moderate calculus deposits" and recommended "patient needs scaling... will submit pre-authorization to Medicaid..." Further review of the resident's record that day revealed no evidence that he received the recommended scaling, one year after it was first prescribed. Interview with the House Manager revealed that to date, the resident had not had the scaling performed and there was no return appointment scheduled. II. The facility failed to demonstrate protection of residents' rights to receive a nourishing, well-balanced, varied and appetizing diet, and where ordered by a physician and/or nutritionist, to a specialized diet [Title 7, Chapter 13, § 7-1305.05(f), formerly § 6-1965(f)], as follows: A. Resident #1 was not observed receiving Instant Breakfast in accordance with physician's orders and there was no Instant Breakfast in the facility on October 12, 2007. When interviewed, the newly-assigned House Manager and direct support staff said the resident normally received the supplement. However, interview and record review revealed that the direct support staff had not been instructed to document the Instant Breakfast in the resident's record. Without documentation, this surveyor could not confirm whether or not the resident had received the supplement twice daily prior to the survey, in accordance with physician's orders. It should be noted that Resident #1's weight chart documented that he had weighed 58 lbs. during	I 002	I002.f.I. Cross refer to w356 and adopted	12/15/07

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I 002	Continued From page 5 the last half of 2006. After he went to the hospital in February 2007 for "persistent diarrhea," his weight dropped to 56 lbs. He held steady at 56 lbs. through May 2007; however, he weighed 55 lbs. in June 2007 and dropped to 54 lbs. in July 2007. A 4 lb. loss in weight represents a 6.9% drop in overall body weight. B. According to Resident #2's physician's orders, dated October 1, 2007, he was prescribed Boost nutritional supplement three times daily, to be served in between meals. Observations and interviews revealed that the Boost was not being offered between meals. Instead, the resident was offered Boost immediately after he refused to finish the foods served at meals in the home and at his day program. C. As noted in paragraph 2.a. above, it was determined on October 12, 2007 that Resident #1 had not received his prescribed Instant Breakfast supplement during the survey period. At 10:09 AM, the House Manager indicated that Resident #4 also was to receive Instant Breakfast, once daily. The resident was not observed receiving the supplement during the survey, neither the House Manager nor direct support staff had mentioned this supplement as part of the client's dietary regimen, there was no Instant Breakfast in the home on October 12, 2007 and the facility had not instituted a formal means for staff to document giving the resident the Instant Breakfast, in accordance with his physician's orders. Also see Federal Deficiency Report - Citation W460 III. The facility failed to demonstrate protection of residents' rights to have their personal records	I 002	I002.f.II.a, b and c Cross refer to W460 and adopted	10/26/07 and ongoing

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I 002	Continued From page 6 kept current, and maintained in a manner that protects privileged and confidential information [Title 7, Chapter 13, § 7-1305.12, formerly § 6-1972], as follows: A. On October 10, 2007, at 5:35 PM, a note was observed posted openly on a cabinet door in the kitchen. Review of the note revealed that it included Resident #2's full name and a listing of foods that he was to avoid eating due to a medical condition. This practice failed to ensure the confidentiality of the residents' personal information. B. As per subsection (5), the facility failed to ensure that Resident #2's record reflected all diagnostic procedures. The record reflected that he was evaluated by a gastro-intestinal (GI) specialist on August 21, 2007. There was no evidence of more recent appointments or procedures observed in the resident's record. However, on October 16, 2007 (post-survey), the facility sent to the Department of Health a fax transmittal that included, among other items, a diagnostic report dated September 20, 2007 that had not been in the resident's record at the time of the survey. The report indicated that Resident #2 underwent an upper GI series examination on September 20, 2007 in a hospital radiology clinic. Across the top of the diagnostic report was an 'electronic stamp' indicating that it was sent to the facility earlier that same day (October 16, 2007), almost 1 month after the procedure was performed. It should be noted that there were 2 handwritten notations added to the bottom of the diagnostic report. Whoever made those entries (in the same handwriting) had neither signed nor dated the entries.	I 002	I002.f.III.a, b, c,d, and e Cross refer to W24, W143 and W148 and adopted	11/30/07

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I 002	Continued From page 7 C. As per subsection (7), the facility's Acting Qualified Mental Retardation Professional (QMRP) failed to document the review of, and/or revise habilitation plans once Residents #1 and #2 successfully completed training programs. D. As per subsection (16), the facility failed to show evidence during the survey that staff who were with Resident #1 at the time that he experienced a seizure on May 28, 2007 had documented the signs and symptoms on a seizure report form, in accordance with agency policies. The only information available was that his seizure had lasted 5 minutes and he was subsequently taken to a hospital emergency room for evaluation. On October 16, 2007 (post-survey), the facility sent to the Department of Health a fax transmittal that included, among other items, a seizure report form. The form was dated 5/2 <sic> and described in greater detail the signs and symptoms of a seizure that Resident #1 experienced. Further review of the form revealed a space designated "Signature of RN or MD" had been signed by the facility's designated LPN. The faxed materials did not indicate the source of the seizure report form (where it had been located after the survey ended). E. As per subsection (14), interviews and record review revealed no evidence that the facility had established a policy and procedure that specified how facility staff should document each contact and/or communication with guardians and/or involved family members. Also see Federal Deficiency Report - Citations W124, W143 and W148	I 002		

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I 020	3501.3(l) ENVIRONMENTAL REQ / USE OF SPACE 3501.3 Each GHMRP shall be within easy walking distance of public transportation or demonstrate that it can provide transportation for its residents to the following facilities: (l) Similar facilities. This Statute is not met as evidenced by: Surveyor: 17815 Based on resident and staff interviews and record verification, the GHMRP failed to provide opportunities to participate in community outings of choice, to meet the needs of two of the two residents in the sample. (Residents #1 and #2) The findings include: 1. The facility failed to ensure Resident #1 was afforded the opportunity to attend live theatre (musicals and plays) in accordance with his assessed interest, as evidenced by the following: a. On October 12, 2007, at approximately 4:10 PM, review of Resident #1's Individual Support Plan (ISP), dated March 21, 2007, revealed the following statement on page 7: "Love going to the theatre enjoys musicals as well as plays." Review of his IPP revealed a service objective in his IPP for him to "participate in a minimum of 4 recreational activities per month." However, further review of the program revealed that it failed to outline potential recreational activities of choice. Review of the resident's community outings/ recreational activities record revealed no evidence that he had been to a live theatre during the previous 12 months.	I 020	I020.1.a and 2 - d and adopted Cross refer to W136.1.a	12/15/07 and ongoing

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I 020	Continued From page 9 b. At 5:04 PM, the resident was interviewed in his bedroom. He confirmed that he enjoyed attending live theatre performances but had not had the opportunity to do so. c. At approximately 5:30 PM, interview with the recently-hired House Manager revealed that he was unaware of how community outings were selected. d. At 7:19 PM, interview with 2 direct support staff persons revealed that Resident #1 enjoyed going to the Chateau nightclub on Thursday nights. His record did not, however, reflect outings to the Chateau in recent months. The staff acknowledged that the most recent outing to the Chateau was documented on March 29, 2007. Staff routinely selected activities and the four residents usually went together. They further indicated that since the March 29, 2007 outing to the Chateau, requests for accessing the resident's personal funds to pay for admission to the nightclub (or other activities that cost money) had not been acted upon by administrators at the corporate office. Review of the resident's documented outings revealed that they consisted of outings to parks, supermarkets, shopping malls and/or driving past monuments and government buildings ("sightseeing"), all at no cost. Subsequent review of the resident's financial records for the 9-month period December 31, 2006 - September 28, 2007 revealed that except for a 6-day vacation to Ocean City, MD at the end of July 2007, the resident had not spent any personal funds for anything, community outings included. (Note: According to a bank statement dated September 28, 2007, his bank balance was more than $1,000.)	I 020		

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I 020	Continued From page 10 2. On October 12, 2007, review of Resident #2's record of community outings revealed a listing of group outings that consisted of the same activities documented for Resident #1, namely parks, supermarkets, shopping malls or driving past monuments and government buildings. His record did not reflect individualized outings of personal choice and no recent opportunities to attend social, religious or community group activities.	I 020		
I 024	3501.7 ENVIRONMENTAL REQ / USE OF SPACE Each GHMRP shall show that it can provide outside recreational activities. This Statute is not met as evidenced by: Surveyor: 17815 See Citation I020 above	I 024	I024 Cross refer to I020.1.a - d and I020.2 and adopted	12//15/07 and ongoing
I 040	3502.1 MEAL SERVICE / DINING AREAS Each GHMRP shall provide each resident with a nourishing, well-balanced diet. This Statute is not met as evidenced by: Surveyor: 17815 Based on observation, interview and record review, the GHMRP failed to provide a nourishing, diet in accordance with phsyician's orders, as follows: The findings include: 1. Resident #1 was not observed receiving Instant Breakfast in accordance with physician's	I 040		

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I 040	Continued From page 11 orders and there was no Instant Breakfast in the facility on October 12, 2007. When interviewed, the newly-assigned House Manager and direct support staff said the resident normally received the supplement. However, interview and record review revealed that the direct support staff had not been instructed to document the Instant Breakfast in the resident's record. Without documentation, this surveyor could not confirm whether or not the resident had received the supplement twice daily prior to the survey, in accordance with physician's orders. It should be noted that Resident #1's weight chart documented that he had weighed 58 lbs. during the last half of 2006. After he went to the hospital in February 2007 for "persistent diarrhea," his weight dropped to 56 lbs. He held steady at 56 lbs. through May 2007; however, he weighed 55 lbs. in June 2007 and dropped to 54 lbs. in July 2007. A 4 lb. loss in weight represents a 6.9% drop in overall body weight. 2. According to Resident #2's physician's orders, dated October 1, 2007, he was prescribed Boost nutritional supplement three times daily, to be served in between meals. Observations and interviews revealed that the Boost was not being offered between meals. Instead, the resident was offered Boost immediately after he refused to finish the foods served at meals in the home and at his day program. 3. As noted in paragraph 2.a. above, it was determined on October 12, 2007 that Resident #1 had not received his prescribed Instant Breakfast supplement during the survey period. At 10:09 AM, the House Manager indicated that Resident #4 also was to receive Instant Breakfast, once daily. Resident #4 was not observed receiving	I 040	I040.1,2 and 3 Cross refer to W460 and adopted	10/26/07 and ongoing

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I 040	Continued From page 12 the supplement during the survey, neither the House Manager nor direct support staff had mentioned this supplement as part of the client's dietary regimen, there was no Instant Breakfast in the home on October 12, 2007 and the facility had not instituted a formal means for staff to document giving him the Instant Breakfast, in accordance with his physician's orders.	I 040		
I 047	3502.5 MEAL SERVICE / DINING AREAS Each GHMRP shall be responsible for ensuring that meals, which are served away from the GHMRP, are suited to the dietary needs of residents as indicated in the Individual Habilitation Plan. This Statute is not met as evidenced by: Surveyor: 17815 Based on observation, interview and record review, the facility failed to ensure that Resident #2 received Boost nutritional supplement in between meals, while he was at day program. The finding includes: According to Resident #2's physician's orders, dated October 1, 2007, he was prescribed Boost nutritional supplement three times daily, to be served in between meals. Interviews at the day program revealed that the Boost was not being offered between meals. Instead, it was offered immediately after he ate his lunch. There was no evidence that the GHMRP had determined whether or not the day program had been following the resident's dietary orders prior to the survey.	I 047	I047 Cross refer to W460 and adopted	10/26/07 and ongoing

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I 052	Continued From page 13	I 052		
I 052	3502.10 MEAL SERVICE / DINING AREAS Each GHMRP shall equip dining areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each resident. This Statute is not met as evidenced by: Surveyor: 17815 Based on observation, interview and record review, the GHMRP failed to ensure that Resident #1's coated spoon was made available for use at all meals. The finding includes: On October 10, 2007, at 6:28 PM, Resident #1 was observed eating with a small (child-sized) metal spoon with a blue and green plastic handle. The resident was observed using the same little spoon at breakfast the next morning. On October 12, 2007, at 4:05 PM, review of Resident #1's Individual Support Plan (ISP), dated March 21, 2007, revealed that he was prescribed a coated spoon. At 7:18 PM PM, a direct support staff was asked asked about the coated spoon. She presented a teaspoon with a pink coating and stated that this was the spoon she always presented to the resident. The pink-coated spoon had not been observed previously during the survey.	I 052	I052 Cross refer to W194.a and adopted	10/24/06 and ongoing
I 061	3502.19 MEAL SERVICE / DINING AREAS Each GHMRP shall have effective procedures for cleaning all equipment and work areas used in the preparation and serving of foods.	I 061		

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I 061	Continued From page 14 This Statute is not met as evidenced by: Surveyor: 17815 Based on observation, the facility failed to implement effective procedures to ensure clean and sanitary equipment and work areas used for food preparation and serving. The findings include: On October 12, 2007, at approximately 3:00 PM, inspection of the kitchen revealed: 1. dried/ hard food materials that was encrusted on 3 out of 12 bowls stored in the dish cabinet above the stove; and 2. grease build-up on the inside of the oven.	I 061	I061.1 and 2 Staff have been inserviced on 10/26/2007 on the cleaning and storage of food and the clean of all utensils, equipment and surfaces in the kitchen area. House Manger will monitor on a monthly basis and as needed to ensure compliance. QA will monitor quarterly.	10/26/07
I 062	3502.20 MEAL SERVICE / DINING AREAS Dishes and eating utensils shall be cleaned after each meal and stored to maintain their sanitary condition. This Statute is not met as evidenced by: Surveyor: 17815 See Citation I061 above	I 062	I062 Cross refer to I061 and adopted.	10/26/07
I 072	3503.3(a) BEDROOMS AND BATHROOMS Each bedroom shall be equipped with at least the following items for each resident: (a) Standard single or twin-sized bed; This Statute is not met as evidenced by: Surveyor: 17815 Based on observation, the facility failed to provide	I 072		

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I 072	Continued From page 15 a bed and/or bed mattress suitable to meet the needs of each resident. The findings include: 1. On October 12, 2007, at 3:20 PM, the mattress on Resident #3's bed was sunken, concave in the center and would not provide adequate support. The House Manager stated that he intended to replace the mattress with another one that was on an unused bed nearby. 2. Resident #2's gastro-intestinal specialist had recommended on August 21, 2007 that the head of his bed be elevated. The resident's medical chart indicated that he had ongoing problems with reflux and gastritis. Observations and interviews, however, revealed no evidence that his bed was positioned in accordance with the doctor's recommendation.	I 072	I072 .1 Individual # 3 mattress was replaced on 10/12/2007 with one that was not in service. A new mattress was brought into service on 10/22/2007. House Manager will inspect mattress on a monthly basis to ensure that equipment in good condition. QA will monitor quarterly basis. I072.2. Individual #2. bed has been raise per the G.I. Specialist recommendation on 10/13/2007. DON and QMRP will ensure that all positioning orders are completed as directed.	10/22/07 10/13/07
I 075	3503.3(d) BEDROOMS AND BATHROOMS Each bedroom shall be equipped with at least the following items for each resident: (d) Night stand. This Statute is not met as evidenced by: Surveyor: 17815 Based on observation, the facility failed to provide a night stand for each resident. The finding includes: On October 12, 2007, at 3:30 PM, only one night stand was found in the bedroom shared by Resident #2 and #4. And the one night stand	I 075		

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I 075	Continued From page 16 present was missing a drawer.	I 075	I075 The night stand was replaced and another placed in the room	11/30/07
I 082	3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Surveyor: 17815 Based on observation, the GHMRP failed to properly equip each bathroom with the appropriate items to meet each resident's needs. The finding includes: On October 12, 2007, at approximately 3:28 PM, no paper cups were available in the cup dispenser for the residents' use.	I 082	I082 An individual that lives in the home removes the paper towels and cups from the bathroom. Cups have been placed in the bathroom. Individual is being trained on using the items appropriately.	11/30/07 and ongoing
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Surveyor: 17815 Based on observation, the GHMRP failed to maintain the facility in a safe, clean, orderly and sanitary manner. The findings include:	I 090		

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I 090	Continued From page 17 A walk-through inspection of the facility, conducted on October 12, 2007, beginning at 2:50 PM, revealed the following: Living Room: 1. A segment of a baseboard, approximately 14 inches in length, was peeled outwards, away from the wall behind the recliner. 2. One of the 2 side chairs (black/purple/blue upholstery) had a tear in the upholstery. Dining Room: 1. Two of the 4 chairs at the dining room table (black upholstery) had tears in the upholstery. Kitchen: 1. see Citation I061 above The Basement: 1. The edges on two areas rugs were curled upwards, presenting a potential trip hazard. The House Manager immediately rolled up and removed one of the 2 rugs. Resident #3's Bedroom: 1. Resident #3's toothbrush was stored openly in his toiletry. The tooth brush was exposed to dirt and other potential contaminants. Residents #2 and #4s' Bedroom: 1. Resident #2's toiletry kit held 3 toothbrushes. Two were stored openly in the kit, thereby leaving them exposed to dirt and other potential	I 090	I090 Living Room 1. The base-board has been repaired. 10/16/2007 2. The 2 side chair have been disposed. 10/13/2007 Dining Room The Dining Room Chair are being replaced by 11/30/2007. Kitchen: Cross refer to I061 and adopted The Basement The rug was removed from service Resident#3 Bedroom: The toothbrushes were replaced and storage case purchased. Resident#2 and #4 Bedroom: 1. The toothbrushes were replaced and storage case purchased. 2. The bed spread was removed from service on 10/12/2007 and replaced 3. Cross refer to I075 and adopted. Exterior. The side ramp is being repaired. The house manager has been instructed to check these and all areas in the home on a monthly basis. Maintenance personnel will complete any structural repairs. Staff have been inserviced to report any defect/ needs immediately. QMRP will monitor to ensure compliance.	10/26/2007 10/12/2007 10/14/2007 10/14/2007 10/14/2007 11/30/2007 11/30/2007

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I 090	Continued From page 18 contaminants. The third toothbrush was in a protective case; however, a foul odor was noted upon opening the case. 2. The bed spread on Resident #2's bed had frayed edges. The House Manager removed the bed spread immediately. 3. Also see citation I075 above Exterior: The wood on the lower landing portion of the wheelchair ramp leading to the spot where the facility van remained parked overnight was old and showing signs of rot. The wood sagged when an adult walked across it. There were rotted hand rails on either side of the lower landing, with 1 screw protruding in a location approximately knee high.	I 090		
I 094	3504.5 HOUSEKEEPING Adequate and appropriate storage shall be provided for each food item in accordance with § 3502.17, each piece of cleaning equipment, and each supply, utensil, linen, or other household item. This Statute is not met as evidenced by: Surveyor: 17815 Based on observation and interview, the GHMRP failed to ensure appropriate storage was provided for linens. The finding includes: On October 12, 2006, at approximately 3:10 PM, inspection of the residents' linen closet revealed	I 094	I094 Storage of the linen close was re-organize so that the individual supplies are designated for their personal use only. A padlock was placed on the storage cabinet for cleaning agents on 10/13/2007.	11/15/07

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I 094	Continued From page 19 that towels, wash clothes and sheets were not stored in a manner that identified individuals' names. The House Manager confirmed that the residents shared towels, wash clothes and bed sheets. The facility had not established a means to ensure that each resident had a supply of linens designated for their personal use only.	I 094		
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Surveyor: 17815 Based on observation and interview, the GHMRP failed to ensure that poisonous and/or caustic agents were stored in a locked cabinet. The finding includes: On October 12, 2006, at approximately 2:54 PM, inspection of the basement revealed a cabinet that held cleaning agents was not without a lock. The House Manager stated that Resident #4 routinely used the area, which was near the washing machine and dryer. Resident #4 was observed in that area later that day.	I 095		
I 108	3504.15 HOUSEKEEPING Each GHMRP shall assure that each resident has at least seven (7) changes of clothing appropriate to his or her daily activities. This Statute is not met as evidenced by:	I 108		

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I 108	Continued From page 20 Surveyor: 17815 Based on observation and interview, the facility failed to ensure that each resident was provided with at least seven changes of appropriate clothing. The findings include: A walk-through inspection of the facility, conducted on October 12, 2007, beginning at 2:50 PM, revealed the following: 1. Three out of 7 undershirts in Resident #3's dresser drawers had holes in them or were frayed at the collar. The House Manager immediately removed the shirts from the dresser drawers. The resident did not have al least 7 undergarments in good repair. 2. Two out of 6 undershirts in Resident #2's dresser drawers had holes in them and/or had frayed collars. The House Manager immediately removed the shirts from the dresser drawers. The resident did not have at least 7 undergarments in good repair. This is a repeat deficiency. See State Licensure Report dated December 29, 2006	I 108	I108 Clothing items have been replaced for individual #2 and#3. House manager will monitor on a monthly basis the number and the condition of the clothing available and will replace these items to ensure that adequate supplies are available at all time. QMRP will monitor. QA will monitor on a quarterly basis. Administration will receive a monthly report from the House manager on the clothing needed of the individuals.	10//24/07
I 110	3504.17 HOUSEKEEPING Each GHMRP shall ensure that each resident ' s clothing is kept in good condition, laundered, and cleaned. This Statute is not met as evidenced by: Surveyor: 17815 see Citation I108 above	I 110	I110 Cross refer to I108 and adopted.	10/24/07

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I 111	Continued From page 21	I 111		
I 111	3504.18 HOUSEKEEPING Each GHMRP shall establish sorting and washing procedures to ensure adequate sanitation either by assisting the residents to perform these tasks or by performing the tasks for the residents as indicated in the their Individual Habilitation Plan (IHP). This Statute is not met as evidenced by: Surveyor: 17815 Based on observation and interview, the facility failed to establish a system to ensure that each resident's personal clothing items were stored for their use only. The findings include: On October 12, 2007, at 3:29 PM, a pair of jeans shorts with Resident #4's initials was observed in Resident #3's dresser drawers. The House Manager said Resident #4 used to share the room with Resident #3. The House Manager immediately removed the shorts from Resident #3's drawers.	I 111		
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Surveyor: 17815 Based on record record review, the facility failed to hold evacuation drills quarterly on all shifts.	I 135		

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I 135	Continued From page 22 The finding includes: On October 11, 2007, fire drill records were reviewed for the 12-month period of September 1, 2006 to August 30, 2007. There was no documented evidence that fire drills were conducted, on any shift, during a 5 1/2-month period between February 5, 2007 and July 29, 2007. Records did, however, reflect that since July 2007, the facility had conducted fire drills timely on each shift. This is a repeat deficiency. See Federal Deficiency Report, dated December 29, 2006 - Citation W440	I 135		
I 169	3507.4(g) POLICIES AND PROCEDURES The manual shall incorporate policies and procedures for at least the following: (g) Resident life, which covers clothing, management of funds, resident rights, discipline, behavior management, services, parental and guardian involvement, visitation, staff treatment of residents, and resident work. This Statute is not met as evidenced by: Surveyor: 17815 Based on observation, interview and record review, the GHMRP's governing body failed to establish and implement policies and procedures regarding parental and guardian involvement. The finding includes: The governing body failed to establish and implement policies and procedures that specified	I 169		

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I 169	Continued From page 23 how facility staff should document each contact and/or communication with guardians and/or involved family members in the residents' records. Also see Federal Deficiency Report - Citations W124, W143 and W148	I 169		
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Surveyor: 17815 See Federal Deficiency Report - Citations W104 and W159	I 180		
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents ' funds received and disbursed. This Statute is not met as evidenced by: Surveyor: 17815 On October 12, 2007, review of Resident #1's financial records revealed the following: 1. The most recent deposit for Resident #1's bi-weekly stipend check was documented on May 23, 2007. There was no documentation indicating that his stipend/ paychecks received since May had been deposited and/or accounted for. 2. There was a 3-month gap in Resident #1's financial record, between September 29, 2006 -	I 189		

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I 189	Continued From page 24 December 31, 2006. 3. Resident #1's financial record book (receipts, statements etc.) was in general disarray, with documents out of sequence.	I 189		
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Surveyor: 17815 Based on review of personnel records, the GHMRP failed to document annual review of job descriptions with each employee. The findings include: On October 12, 2007, review of personnel records revealed that all 10 direct support staff (as well as other employees) had received a review of their job description at time of hire. Six (6) of the 10 direct support staff (S1, S2, S3, S5, S6 and S8) had been employed for longer than a year. Of those 6 (longtime) employees, there was no evidence of annual reviews of their job descriptions for any of them, since their time of hire. Note: On October 15 and 16, 2007, the GHMRP submitted additional documentation via facsimile. Review of the faxed documents revealed no evidence of job description reviews for the 6 aforementioned employees. This is a repeat deficiency. See State Licensure Report dated December 29, 2006	I 203		

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I 206	Continued From page 25	I 206		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Surveyor: 17815 Review of personnel records on October 12, 2007 revealed no evidence of a current health certification/inventory for the following individuals working with the residents: - 4 of the 10 direct support staff (S2, S8, S9 and S10), and - 1 of the 4 nurses (N1) - the podiatrist (who provided services onsite, within the group home) Note: The October 12, 2007 review had identified 8 additional personnel records (including consulting health professionals) without evidence of health certificates. On October 15 and 16, 2007, the GHMRP submitted documentation via facsimile verifying current certification for those 8 individuals; therefore they were not cited above. Review of the faxed documents, however, revealed no evidence of health certificates for the 5 employees listed above or the podiatrist. This is a repeat deficiency. See State Licensure	I 206		

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I 206	Continued From page 26 Report dated December 29, 2006	I 206		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Surveyor: 17815 Based on observations, interview and record verification, the GHMRP failed to ensure that continuous, ongoing in-service training programs were conducted for all personnel. The finding includes: See Federal Deficiency Report - Citation W194	I 222	Cross refer to W194 and adopted.	12/15/2007
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Surveyor: 17815 During the Entrance Conference on October 11, 2007, at 11:05 AM, the House Manager stated that the agency expected all staff assigned to work with residents to have current first aid training and CPR certification. On October 12, 2007, review of employee personnel records revealed the following: 1. 4 out of 10 direct support staff (S5, S6, S9 and S10) were without evidence of receiving first aid training within the past 3 years.	I 227	1,2 and 3: The administration will ensure that staff update his/her Health, First Aid and CPR training and a valid copy is filed within their personnel file. House Manager will audit personnel files on a monthly basis and QA will audit on a quarterly basis. The QMRP and the administration will received these audit and re-concile the information to ensure that the records are kept current.	11/30/07

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I 227	Continued From page 27 This is a repeat deficiency. See State Licensure Report dated December 29, 2006 2. 4 out of 10 direct support staff (S4, S5, S8 and S10) were without evidence of current CPR certification. 3. There was no evidence that 1 out of 4 nurses (N2) working in the facility had current CPR certification.	I 227		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Surveyor: 17815 Based on interview and record review, the GHMRP failed to ensure each training program included specialty areas needed by the residents being served. The findings include: Review of the in-service training records on October 12, 2007 failed to show evidence of training to direct support staff and the recently-hired House Manager in the following areas: 1. Residents' communication programs 2. Residents' physical therapy and exercise	I 229	Cross refer to W154 and W194 and adopted.	11/30/07

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I 229	Continued From page 28 programs 3. Residents' adaptive equipment 4. Residents' diet orders Also see Citation I002 above and Federal Deficiency Report - Citations W154 and W194	I 229		
I 260	3512.1 RECORDKEEPING: GENERAL PROVISIONS Each Residence Director shall maintain current and accurate records and reports as required by this section. This Statute is not met as evidenced by: Surveyor: 17815 Based on interview and record review, the facility failed to maintain current and accurate records of residents' supports and services. The findings include: 1. The facility failed to ensure that Resident #2's record reflected all diagnostic procedures. On October 12, 2007, review of Resident #2's record revealed that he had been seen by GI specialists several times, and undergone diagnostic procedures, since he had surgery on a hiatal hernia in June 2006. The most recent GI appointment documented was on August 21, 2007. It was later determined that additional tests had occurred but had not been documented appropriately in the resident's record. On October 16, 2007, the facility sent to the State agency a fax transmittal that included, among other items, a diagnostic report dated September 20, 2007 that had not been in the resident's	I 260	Cross refer to W104 and W149 and adopted.	11/30/07

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I 260	Continued From page 29 record at the time of the survey. The report indicated that Resident #2 underwent an upper GI series examination on September 20, 2007 in a hospital radiology clinic. Across the top of the diagnostic report was an 'electronic stamp' indicating that it was sent to the facility earlier that same day (October 16, 2007), almost 1 month after the procedure was performed. It should be noted that there were 2 handwritten notations added to the bottom of the diagnostic report. Whoever made those entries (in the same handwriting) had neither signed nor dated the entries, as required by regulation. 2. The facility failed to show evidence during the survey that staff who were with Resident #1 at the time that he experienced a seizure on May 28, 2007 had documented the signs and symptoms on a seizure report form, in accordance with agency policies. The only information available was that his seizure had lasted 5 minutes and he was subsequently taken to a hospital emergency room for evaluation. On October 16, 2007, the facility sent to the Department of Health a fax transmittal that included, among other items, a seizure report form. The form was dated 5/2 <sic> and described in greater detail the signs and symptoms of a seizure that Resident #1 experienced. Further review of the form revealed a space designated "Signature of RN or MD" had been signed by the facility's designated LPN. The faxed materials did not indicate the source of the seizure report form (where it had been located after the survey ended). 3. Interviews and record review revealed no evidence that the facility had established a policy	I 260	Cross refer to W104 and W149 and adopted.	11/30/07

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I 260	Continued From page 30 and procedure that specified how facility staff should document each contact and/or communication with guardians and/or involved family members. See Federal Deficiency Report - Citations W104 and W149	I 260		
I 274	3513.1(e) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (e) Signed agreements or contracts for professional services; This Statute is not met as evidenced by: Surveyor: 17815 Based on record review, the GHMRP failed to provide evidence of a written agreement or contract with the consulting podiatrist. The finding includes: Interview with the Acting Qualified Mental Retardation Professional (AQMRP) and review of the personnel records on October 12, 2007 revealed the GHMRP failed to have contract on file for the podiatrist. The AQMRP first stated that this was because residents went to the podiatrist's office, out in the community. However, after it was pointed out that Resident #1's record indicated that he was "seen at home" on June 30, 2007, the AQMRP acknowledged that the podiatrist provided treatment within the group home, as it was "easier for the" residents.	I 274	A request for the necessary credential, health, resume, license and contract agreement has been made to the consultant podiatrist. Symbral will ensure that a file is maintained on all consultants who provide services in the home.	11/30/07

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I 274	Continued From page 31 It should be noted that on October 11, 2007 a request was made to see personnel records for all employees and consultants, the was no file made available for review for the podiatrist before the survey ended the next evening.	I 274		
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Surveyor: 17815 See Citation I260 above	I 291	Cross refer to W260 and adopted.	11/30/07
I 292	3514.3 RESIDENT RECORDS Each record shall include, but not be limited to, the requirements of D.C. Law 2-137, D.C. Code § 6-1972 (1989 Repl. Vol.). This Statute is not met as evidenced by: Surveyor: 17815 See Citation I002, section III(A-E) above	I 292	Cross refer to I002.III.a - e and adopted.	11/30/07
I 374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident ' s guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident ' s status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Surveyor: 17815	I 374		

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I 374	Continued From page 32 Based on interview and record verification, the facility failed to notify residents' legal guardians of significant changes in health condition and/or incidents involving injuries, for the one (out of two sampled) resident with a court-appointed guardian. (Resident #2) The findings include: During the October 11, 2007 Entrance Conference, at approximately 11:20 AM, the House Manager indicated that Resident #2 had a court-appointed guardian. Moments later, he presented the resident's Individual Support Plan, dated April 5, 2007, in which the guardian "for medical purposes only" was documented. On October 12, 2007, at 2:01 PM, review of the resident's medical chart revealed a court document that documented the appointment of the medical guardian, effective July 19, 2001. 1. On October 11, 2007, at 8:21 AM, review of incident reports revealed that Resident #2 was taken to an emergency room on May 31, 2007, after he sustained an injury to his forehead. Further review of the incident report failed to show evidence that the medical guardian had been informed. 2. On October 12, 2007, at approximately 1:15 PM, interview with the Acting Qualified Mental Retardation Professional indicated that the facility's policies stated that notification of residents' families and guardians would follow major incidents, such as emergency room visits, and this would be documented on the incident report. Notification of such incidents should be documented on the incident report. She stated that she would seek written evidence that the guardian was contacted about the May 31, 2007	I 374	Cross refer to W124 and adopted.	11/30/07

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I 374	Continued From page 33 emergency room visit. No written evidence that the guardian was informed of the aforementioned incident was presented before the end of the survey later that evening. 3. On October 15, 2007, at 2:20 PM, Resident #2's medical guardian was interviewed by telephone. The guardian indicated that he had not been informed of any unusual incidents during the past 12 months. Also see Federal Deficiency Report - Citation W124. This is a repeat deficiency. See Federal Deficiency Report, dated December 29, 2006 - Citation W148.	I 374		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Surveyor: 17815 Based on interview and record review, the GHMRP failed to ensure that the Department of Health, Health Regulation Administration, was notified immediately by telephone and in writing within 24 hours of all incidents that placed the	I 379	Cross refer to W149.1 and 2.a and b. QMRP will ensure that HRA is notified immediately and in writing within 24 hours of incident. Incident Management Coordinator and QA will monitor to ensure compliance.	10/13/07 and ongoing

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I 379	Continued From page 34 resident at risk, for two of the four residents of the facility. (Residents #1 and #2) The findings include: 1. On October 11, 2007, beginning at 8:20 AM, review of incident reports revealed that on May 31, 2007, Resident #2 was taken to a hospital emergency room after sustaining a laceration to his forehead. There was no evidence that this incident was reported to HRA as required. 2. According to an incident report dated February 22, 2007, Resident #1 was transported from his day program to a hospital emergency room via ambulance after experiencing lethargy. There was no evidence that this incident was reported to HRA as required. 3. According to an incident report dated September 11, 2007, Resident #1 was taken to a hospital emergency room after experiencing stomach pain, vomiting and diarrhea. The incident was reported to HRA by telephone on September 14, 2007, 3 days after he was admitted to the hospital. During the exit teleconference on October 15, the Acting QMRP stated that she recalled having instructed her staff to notify the Department of Health on the day of the incident. There was no written evidence, however, to verify that staff had carried out her instructions. This is a repeat deficiency. See Federal Deficiency Report, dated December 29, 2006 - Citation W153.	I 379	Cross refer to W149.1 and 2.a and b. QMRP will ensure that HRA is notified immediately and in writing within 24 hours of incident. Incident Management Coordinator and QA will monitor to ensure compliance.	10/13/07 and ongoing
I 404	3520.6 PROFESSION SERVICES: GENERAL PROVISIONS	I 404		

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I 404	Continued From page 35 Each professional service provider shall assist, as appropriate, each other person who is working with a resident in the GHMRP so that relevant professional instructions can be implemented through-out the resident ' s programs and daily activities. This Statute is not met as evidenced by: Surveyor: 17815 Based on staff interview and record review, the GHMRP failed to ensure the implementation of recommendations made by the Speech Language Therapist and Physical Therapist. The findings include: See Citations I002, sections I and II, above, and the Federal Deficiency Report - Citations W194 and W436	I 404	Cross refer to W194 and W436 and adopted.	12/15/07
I 407	3520.9 PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall obtain from each professional service provider a written report at least quarterly for services provided during the preceding quarter. This Statute is not met as evidenced by: Surveyor: 17815 Based on staff interview and record review, the GHMRP failed to provide evidence that the Speech Language Therapist and Physical Therapist periodically reviewed the residents' programs, for two of the two residents in the sample. (Residents #1 and #2) The findings include: Resident #1's team met on March 21, 2007 to	I 407	Cross refer to W159.7, W194 and W436. QMRP will ensure that consultants that recommend formalized provide progress reports on the program implementation. Consultants will provide initial training for the goal with the QMRP providing follow-on and support training.	12/15/07

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I 407	Continued From page 36 review and update his annual plan. Resident #2's team had done the same on March 6, 2007. Both residents had communication programs and physical therapy/ exercise programs. On October 12, 2007 (more than 6 months later), review of their clinical records revealed no evidence that the consultants had returned to the facility to monitor the implementation of the programs or to review their progress. It should be noted that the survey revealed a lack of staff training and failure to implement the programs, as written. See Citation WI002, section I(A-E) and Federal Deficiency Report - Citations W159.7, W194 and W436	I 407	Cross refer to W159.7, W194 and W436. QMRP will ensure that consultants that recommend formalized provide progress reports on the program implementation. Consultants will provide initial training for the goal with the QMRP providing follow-on and support training.	12/15/07
I 411	3520.12 PROFESSION SERVICES: GENERAL PROVISIONS Professional services personnel shall participate, as appropriate, on committees concerned with the GHMRP ' s programs and operations. This Statute is not met as evidenced by: Surveyor: 17815 Based on interview and review of committee minutes, the GHMRP failed to enlist the participation on the Infection Control Committee of professionals identified in the agency's policies and procedures manual. The finding includes: On October 12, 2007, at 8:54 AM, review of the facility's policies and procedures manual revealed that the Infection Control Committee should include participation by the medical director and dietitian, among others. When asked about the committee later that day, at 1:04 PM, the Director of Nursing stated that committee membership	I 411		

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I 411	Continued From page 37 consisted of "mainly the nurses and managers." Subsequent review of the committee's minutes dated August 17, 2006 and February 7, 2007 confirmed that membership consisted of nurses and House Managers. Further interviews and record review failed to show evidence that other professionals' participation on the committee had been sought.	I 411	Symbral will ensure that the Infection Control Committee have other professional participation. Administration will be provided a copy of the meeting minutes. QA will monitor quarterly to ensure compliance.	12/15/07 and ongoing
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Surveyor: 17815 Based on observation, interview and record review, the facility failed to provide habilitation, training and assistance in accordance with residents' Individual Support Plans (ISPs), for two of the two residents in the sample. (Residents #1 and #2) The findings include: 1. During observations at dinner on October 10, 2007 and at breakfast the following morning, Resident #1 ate with a small (child-sized) metal spoon with a blue and green plastic handle. Review of the resident's record on October 12, 2007 revealed that he was prescribed a plastic-coated spoon for use at all meals. Upon inquiry at 7:18 PM, staff presented a coated spoon (pink) which had not been used by the resident during the survey. Review of staff in-service training records revealed no evidence that the staff observed working with the resident on October 10 and 11, 2007 had received training	I 422	Cross refer to W159 and W436.1 and adopted.	12/15/07 and ongoing

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I 422	Continued From page 38 on the use of his coated teaspoon. Also see Federal Deficiency Report - Citations W159 and W436.1. 2. Resident #1 was observed in the home on the evening of October 10, 2007 and again the next morning, followed by day program observations and then additional observations that afternoon (October 11, 2007) in the home. At no time was the resident observed using elbow of knee pads while he moved about 'on all fours.' However, on October 12, 2007, review of Resident #1's ISP, dated March 21, 2007, revealed: "elbow and knee guards were prescribed to prevent injury to these areas of his body as he uses his elbows and knees to mobilize when indoors <client's name> prefers self-ambulation when indoors." At 5:10 PM, the resident said he required staff assistance with putting them on. At 7:08 PM, two direct support staff were asked about the pads. They incorrectly stated that the pads should be worn when he was out in the community. Further interview revealed that staff were unaware that he should wear them while in the home. Review of staff in-service training records revealed no evidence that the staff observed working with the resident on October 10 and 11, 2007 had received training on the use of his protective elbow and knee pads.. Also see Federal Deficiency Report - Citations W159 and W436.2. 3. Staff interview and review of in-service training records revealed that staff had not received training on the use of Resident #1's "Elbow Comfy Splint" that remained in it's shipping carton. Staff also confirmed that the item had been received in late May 2007, as per the date	I 422	Cross refer to W159 and W436.2 and adopted. Cross refer to W159 and W436.3 and adopted.	12/15/07 and ongoing 12/15/07 and ongoing

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I 422	Continued From page 39 marked on the shipping label. Also see Federal Deficiency Report - Citations W159 and W436.3. 4. The facility failed to ensure staff displayed competency in implementing Resident #2's shoulder exercise program using a pulley. On October 12, 2007, review of Resident #2's annual PT assessment, dated February 27, 2007, revealed that the physical therapist had recommended a shoulder exercise program involving the use of a pulley. Observations and staff interviews had not previously indicated the use of a pulley for the resident's exercise program. At 7:35 PM, two direct support staff and the recently-hired House Manager presented a shipping box that contained Resident #2's shoulder exercise pulley. Further interviews and review revealed that (a) the pulley had been delivered in February 2007, (b) to date, the resident had not used the pulley, (c) staff had not been trained on the proper use, and (d) "someone" (staff not sure who) had not showed up at a previous staff meeting for in-service training (date not specified) and no additional in-service training had been provided to date. Also see Federal Deficiency Report - Citations W159 and W436.3. 5. The facility failed to ensure that staff had the necessary information and training to ensure proper implementation and documentation of Resident #1's communication training program. There was no evidence that the QMRP had met with staff to decide upon the 10 wh and/or how questions they were to ask the resident when implementing the program. Staff were not writing down the wh and/or how questions they asked, in	I 422	Cross refer to W159 and W436.3 and adopted.	12/15/07 and ongoing

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I 422	Continued From page 40 accordance with the program as written by the speech/ languag therapist. Staff had used a + sign to document that they asked the resident a question but did not document the resident's response, as indicated in the program. The House Manager and staff indicated that they had not received training from either the speech/ language therapist or the QMRP on how to implement the residents' communication programs. In-service training records showed no evidence that staff had received training on how to implement the residents' communication programs. Also see Federal Deficiency Report - Citation W159.8.	I 422	Cross refer to W159.8 and adopted.	12/15/07 and ongoing
	6. The facility failed to ensure timely dental follow-up for Resident #1. On October 12, 2007, at 4:13 PM, review of Resident #1's dental record revealed that he received a dental assessment on October 4, 2006. On October 4, 2006, the dentist documented "heavy calculus deposits" and recommended "patient needs scaling... will submit pre-authorization to Medicaid..." The resident's record documented a return visit to the dentist on June 6, 2007, at which time the dentist found "moderate calculus deposits" and recommended "patient needs scaling... will submit pre-authorization to Medicaid..." Further review of the resident's record that day revealed no evidence that he received the recommended scaling, one year after it was first prescribed. Interview with the House Manager revealed that to date, the resident had not had the scaling performed and there was no return appointment scheduled.		Cross refer to W460 and adopted.	10/26/07 and adopted
	7. Resident #1 was not observed receiving Instant Breakfast in accordance with physician's		Cross refer to W460 and adopted	10/26/07 and adopted

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I 422	Continued From page 41 orders and there was no Instant Breakfast in the facility on October 12, 2007. When interviewed, the newly-assigned House Manager and direct support staff said the resident normally received the supplement. However, interview and record review revealed that the direct support staff had not been instructed to document the Instant Breakfast in the resident's record. Without documentation, this surveyor could not confirm whether or not the resident had received the supplement twice daily prior to the survey, in accordance with physician's orders. It should be noted that Resident #1's weight chart documented that he had weighed 58 lbs. during the last half of 2006. After he went to the hospital in February 2007 for "persistent diarrhea," his weight dropped to 56 lbs. He held steady at 56 lbs. through May 2007; however, he weighed 55 lbs. in June 2007 and dropped to 54 lbs. in July 2007. A 4 lb. loss in weight represents a 6.9% drop in overall body weight. 8. According to Resident #2's physician's orders, dated October 1, 2007, he was prescribed Boost nutritional supplement three times daily, to be served in between meals. Observations and interviews revealed that the Boost was not being offered between meals. Instead, the resident was offered Boost immediately after he refused to finish the foods served at meals in the home and at his day program. Also see Federal Deficiency Report - Citation W460 9. Resident #2's gastro-intestinal specialist had recommended on August 21, 2007 that the head of his bed be elevated. The resident's medical chart indicated that he had ongoing problems with	I 422	Cross refer to W460 and adopted.	10/26/07 and adopted

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I 422	Continued From page 42 reflux and gastritis. Staff interviews on October 10 and 11, 2007, at 6:53 PM and 10:52 AM, respectively, observation of Resident #2's bed and bedroom on October 12, 2007, and review of his chart on October 12, 2007, beginning at approximately 9:25 AM, revealed no evidence that facility nurses ensured that the head of Resident #2's bed was kept elevated, in accordance with the gastro-intestinal specialist's August 21, 2007 recommendation. Resident #2's HMCP had been reviewed and updated by the consulting RN on September 29, 2007. However, review of the HMCP revealed that it did not reflect the gastro-intestinal specialist's August 21, 2007 recommendation to keep the head of his bed elevated.	I 422	Cross refer to I072.2. Individual #2. bed has been raise per the G.I. Specialist. 10/13/2007. DON and QMRP will ensure that all positioning orders are completed as directed. Charge Nurse and DON will monitor to ensure that all orders are implement and documented in a timely manner.	10/13/07 and ongoing
I 424	3521.5(a) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client: (a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan; This Statute is not met as evidenced by: Surveyor: 17815 Based on observations, staff interviews and record review, the Acting Qualified Mental Retardation Professional (QMRP) failed to review and revise the Individual Program Plan (IPP) once the resident successfully completed an objective identified in the IPP, for two of the two residents in the sample. (Residents #1 and #2) The findings include: The facility's Acting QMRP failed to revise	I 424	Cross refer to W255 and adopted.	12/15/07

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I 424	Continued From page 43 Resident #1's and #2's program objectives after several months of the residents' demonstrating successful completion of the objectives. See Federal Deficiency Report - Citaion W255	I 424		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Surveyor: 17815 A. Based on interview and record verification, the facility failed to ensure the right of each resident's legal representative to be informed of the resident's medical condition and proposed procedures, for one of the two residents in the sample. (Resident #2) The findings include: During the October 11, 2007 entrance conference, at approximately 11:20 AM, the House Manager indicated that Resident #2 had a court-appointed guardian. Moments later, he presented the resident's Individual Support Plan, dated April 5, 2007, in which the guardian "for medical purposes only" was documented. On October 12, 2007, at 2:01 PM, review of the resident's medical chart revealed a court document appointing the medical guardian, effective July 19, 2001. On October 12, 2007, at 9:21 AM, review of a report prepared by Resident #2's medical	I 500	Cross refer to W124 and W148 and adopted.	11/30/07 and ongoing

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I 500	Continued From page 44 guardian, dated July 19, 2006, revealed "a couple of hospitalizations for gastric problems" during the previous year. The guardian's most recent documented visit to the facility was June 25, 2006. The resident's medical chart revealed that he had undergone surgery in June 2006 to repair a hiatal hernia, and had a history of GI bleeding, mild esophagitis, Barrett's esophagus syndrome and left sided colitis. Further review of the resident's record revealed the following: 1. Resident #2 had an ultrasound procedure of the abdomen performed on October 5, 2006. 2. He had undergone upper GI tests on October 24, 2006. This was 3 months after the last documented contact by the facility to the medical guardian. 3. A case conference was held on December 7, 2006 at which time some members of his interdisciplinary team met to review 3 reports prepared by an outside entity regarding his nutritional intake and the use of Boost nutrition supplement three times daily. 4. The former House Manager documented a June 14, 2007 visit to a GI clinic at which time the doctor refused to provide services and referred Client #2 back to the doctor who had performed the hernia operation in June 2006. 5. There were visits to GI consultants on June 26, 2007 and on August 21, 2007 (reflected "episodes of vomiting in June..." and recommended "patient should have head of bed elevated" and a "barium swallow study with upper GI series..." It should be noted that one of the GI specialists contacted by the facility since then had refused to serve the resident because he no	I 500	Cross refer to W124 and W148 and adopted.	11/30/07 and ongoing

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I 500	Continued From page 45 longer accepted DC Medicaid insurance. The resident's record, however, failed to show evidence that the medical guardian had been kept informed by the GHMRP of the resident's ongoing gastro-intestinal status and appointments, as outlined above. 6. On October 12, 2007, at approximately 1:15 PM, interview with the Acting Qualified Mental Retardation Professional (AQMRP) indicated that she believed that Resident #2's medical guardian had been notified of the resident's medical issues and team meetings. Further interviews and record review, however, revealed no evidence that the facility had established a policy and procedure that specified how facility staff should document each contact and/or communication with guardians (and/or involved family members). 7. On October 16, 2007, the facility sent to the State agency a fax transmittal that included, among other items, a diagnostic report dated September 20, 2007 that had not been in the resident's record at the time of the survey. The report indicated that Resident #2 underwent an upper GI series examination on September 20, 2007 in a hospital radiology clinic due to "nausea and vomiting." The report's conclusion included the following: "Moderate sized hiatal hernia with distal esophageal stricture. Would recommend upper endoscopy to correlate further." The documentation, however, did not reflect any contact with the resident's medical guardian. 8. A telephone interview with Resident #2's medical guardian on October 15, 2007, at 2:20 PM, revealed that he had not been notified of the resident's medical consultations or health status during the past 12 months.	I 500	Cross refer to W124 and W148 and adopted.	11/30/07 and ongoing

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I 500	Continued From page 46 See Federal Deficiency Report - Citations W124 and W148 B. Based on interviews and record verification, the facility failed to promote the participation of family members and/or legal guardians in the active treatment process, for two of the two residents in the sample. (Residents #1 and #2) See Federal Deficiency Report - Citation W143 C. Based on interviews and record verification, the facility failed to establish and/or implement policies that ensured the health and safety of its residents, for two of the four residents residing in the facility. (Residents #1 and #2) The findings include: 1. Although the Acting QMRP stated that all incidents, including injuries of unknown origin, were reported immediately to their administrator, review of incident-related documentation failed to show evidence that their administrator was being notified. Review of the agency's Incident Management policies revealed that they did not specify how facility staff should document said notification. Further interview with the Acting QMRP and the Incident Management Coordinator confirmed that there was no established policy proscribing how the notification of their administrator should be documented. 2. Cross-refer to Federal Deficiency Report - Citation W153 and Citation I379 above. The facility failed to consistently report significant incidents, including injuries of unknown origin, to the Department of Health and on a timely basis. For example, Resident #1's emergency room visit	I 500	Cross refer to W143 and adopted. Cross refer to W1491. and 2.a and b and adopted. Cross refer to W153 and I379 and adopted.	11/30/07 and adopted 11/30/07 11/30/07

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I 500	Continued From page 47 on February 22, 2007 due to lethargy, and Resident #2's emergency room visit on May 31, 2007 after sustaining a laceration to his forehead, were not reported. 3. Cross-refer to Federal Deficiency Report - Citation W154. The facility failed to promptly investigate Resident #2's injury, after staff presented contradictory information, to determine whether its policies prohibiting abuse and neglect had been implemented. 4. Cross-refer to Federal Deficiency Report - Citation W156. The facility failed to consistently report the results of all incident investigations within 5 working days. For example, Resident #2's May 31, 2007 incident investigation report was dated June 21, 2007 and there was no documented evidence that the administrator had been notified of the results prior to issuance of the report. In addition, the resident's medical guardian and the Department of Health were not made aware of the incident or the investigative findings. D. Based on observation, the facility failed to implement an effective system to protect the residents' rights for privacy during medication administration, for three of the four residents of the facility. (Residents #1, #2 and #4) The findings include: The evening medication pass was observed on October 10, 2007, beginning at 5:50 PM. The medication nurse did not protect the residents' right to privacy during the administration of medications, as they were all gathered at the dinner table in the dining room.	I 500	Cross refer to W154 and adopted. Cross refer to W156 and adopted. Cross refer to W130 and adopted.	11/30/07 11/30/07 11/30/07

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I 500	Continued From page 48 This is a repeat deficiency. See Federal Deficiency Report, dated October 14, 2005 - Citation W130 E. Based on resident and staff interviews and record verification, the facility failed to provide opportunities to participate in community outings of choice, to meet the needs of two of the two residents in the sample. (Residents #1 and #2) The findings include: 1. The facility failed to ensure Resident #1 was afforded the opportunity to attend live theatre (musicals and plays) in accordance with his assessed interest. He also had not been taken to a weekly dance club (also a known preferred activity) since March 2007. Staff reported problems accessing the resident's funds for this and other activities in the community. 2. Resident #2's records also failed to reflect social or community activities of personal choice/ preference. See Federal Deficiency Report - Citation W136	I 500	Cross refer to W136 and adopted. Cross refer to W136 and adopted.	12/15/07 12/15/07

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R 122	4701.2 BACKGROUND CHECK REQUIREMENT Except as provided in section 4701.6, each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Abuse Registry, before employing or using the contract services of an unlicensed person. This Statute is not met as evidenced by: Surveyor: 17815 There was no evidence that the GHMRP obtained a criminal background check for one of the ten direct support staff. The personnel file for this employee (S5) indicated an initial hire date of 4/30/99; however, interview with the Acting QMRP/ Director of Nursing indicated that the employee had left the agency for a while. She was unsure of the date when the employee was rehired. There was no background check evidenced for either periods of employment.	R 122		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Surveyor: 17815 Based on the review of personnel records, the GHMRP failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check.	R 125		

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R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Surveyor: 17815 Based on the review of personnel records, the GHMRP failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check.	R 125		

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R 125	Continued From page 1 The findings include: Review of the personnel files on October 12, 2007 revealed no evidence of comprehensive criminal background checks for 3 of the 10 direct support staff, as follows: S5 - no background check documented (date of hire not indicated) S9 - A DC check was documented; however, she lived in Maryland S10 - Maryland and DC checks were documented; however, he had worked in VA;	R 125	Cross refer to R122 and adopted.	11/30/07